











Welcome & Purpose

What is the IAMHP Comprehensive Billing Manual?

The IAMHP Comprehensive Billing Manual ("the Manual") is designed to provide support and guidance to contracted Medicaid managed care providers on billing for services to Medicaid beneficiaries. This manual only applies to Health Choice Illinois (HCI) Managed Care Organizations ("MCOs") and for services provided to Medicaid beneficiaries in Medicaid-only programs (e.g. FHP, ACA, ICP and LTSS populations). It does NOT apply to dually-eligible beneficiaries in the Medicare Medicaid Alignment Initiative (MMAI) program.

The Manual gives providers a one-stop document for billing and claims procedures, without having to look up each health plan and/or provider-specific process separately. IAMHP completed a thorough review and comparison of all member MCO Billing Guides, and working closely with our members, has crafted a single source for all claims policies and procedures, regardless of provider type. The bulk of the Manual provides policies and procedures common to all MCOs; however, there will be a select number of instances where the MCOs may differ in their approach. In these cases, links to MCO-specific guidelines are embedded in the document for easy reference. It is also imperative to always refer to your contractual agreements as you may have specific nuances that apply specifically to you as noted in your agreement. Your provider agreement supersedes items in this manual.

The Manual is a dynamic document and updates and revisions will be provided at least quarterly, or more frequently if required. Providers will be notified when the Manual is updated. The full, updated manual and modification/update grid will be posted on the IAMHP website. It is recommended that all providers review the Manual on a regular basis to ensure the most up-to-date information is being utilized.

Modification History

Version	Date	Section Modification	Description
27.0	1/5/23	IV. Claim Disposition	Updates to links and addresses for Meridian for EOP access, corrected claim and dispute submissions
27.0	1/5/23	IX. Long Term Care Services E. Patient Credit File F. Billing Requirements	 Clarification added regarding Day of Discharge (non—payable unless due to death). Addition of billing guidance for when member transfers between levels of care within same facility
27.0	1/5/23	XIII. Community Behavioral Health Services D. Pathways to Success	Addition of Billing Guidance for the Pathways to Success program effective 1/1/2023
27.0	1/5/23	New Section Added	DPP and DSMES Services
27.0	1/5/23	XIII. Community Behavioral Services C. Coding Guidance	Updates to Services table to include IATP: LPHA review and changes to Clinical Assessment Tool codes/modifiers effective 7/1/22
27.0	1/5/23	XI. FQHCs, RHCs, and Encounter Rate Clinics F. Coding Requirements ii. Specific Encounter Clinic Billing Information	 Change to Procedure Code T1040 for behavioral health encounters beginning with dates of service on 2/1/23
26.0	10/26/22	XIII. Community Behavioral Services C. Coding Guidance	Correction to POS 10 to be an on-site POS
26.0	10/26/22	XXII. Vision iii. MCO Vision Vendors v. Claim Submission Methods	Update to BCCHP Vision Vendor to Heritage Vision, effective with DOS 4/1/22
25.0	7/20/22	XI. FQHCs, RHCs and Encounter Rate Clinics F. Coding Requirements ii. Specific Encounter Clinic Billing Information	Addition of Modifier 93 when delivering telehealth services via AUDIO ONLY and POS code 10 when Originating Site is the Patient's Home
25.0	7/20/22	XIII. Community Behavioral Services C. Coding Guidance	 Addition of Modifier 93 and POS code 10 when delivering telehealth services via AUDIO ONLY Addition of Violence Prevention - Community Support Team (VP-CST) services into Group B services table Addition of notations regarding Crisis Stabilization Services change in units Change to the use of HK modifier when providing Community Support Services in a residential setting
25.0	7/20/22	XXVI. Specialized Mental Health Rehabilitation Facilities F. Coding Requirement	Note added regarding using appropriate revenue code for add-on payments.
25.0	7/20/22	VI. Inpatient Hospital C. Coding Guidance ix. Coverage and/or Service Changes during an Inpatient Stay	Guidance added regarding how to bill when a patient is transported to another facility for services and returns to admitting hospital the same day.
25.0	7/20/22	XXVII. Anesthesia G. Anesthesia	Guidance added regarding billing for office-based pain management services.

Version	Date	Section Modification	Description
25.0	7/20/22	VI. Inpatient Hospital C. Coding Guidance iv. Covered and Non-Covered Days	Clarification added for Aetna Better Health of Illinois
25.0	7/20/22	XIV. Transportation Services	 Clarification on MMAI billing for non-emergency ground ambulance Addition of the Certificate of Transportation Services form for non-emergency transports originating at a member's residence
24.0	5/2/22	IV. Claim Dispostion B. Provider Type vi. Operpayments/Recoupments	Updated timeframe for recoupment from 18 to 12 months
24.0	5/2/22	XXIII. Pharmacy Providers D.i. Retail Point-of-Sale (POS) Pharmacy Services	Meridian PBM Vendor change to CVS Caremark
24.0	5/2/22	V. Outpatient Hospital C. Coding Guidance – EAPG Pricing	 ii. EAPG Changes with DOS 7/1/2020: Updates to taxonomy rules for PT/OT (COS 24 and COS 29) Updates to Psychiatric Services (cannot bill COS 027 and COS 028 on same claim) Changes to Billing with Different Taxonomies for Multiple HFS COS New Section Added – Outpatient Dialysis Services
24.0	5/2/22	New Appendix Added	Appendix K – MCO Complaint Tracking Process
24.0	5/2/22	XIX. SUPR C.iv. Coding Guidance – Interim Claims	Clarification added regarding Interim Claims and billing for stays exceeding 30 days.
24.0	5/2/22	XIII. Community Behavioral Service (CBS)	 Updates and clarifications regarding provision of services via telehealth Addition of Therapy/Counseling – Brief Intervention as billable service
24.0	5/2/22	Appendix I – Administrative Days	Updates and clarifications regarding Bill Types to be used in Admin Days Billing, including UB-04 sample claims
24.0	5/2/22	VIII. Supportive Living Facilities F. Billing Requirements	Clarifying language added regarding Leave of Absence billing requirements
24.0	5/2/22	VI. Inpatient Hospital C-ii Coding Guidance – Value Codes	Updated Value Code 54 to 28 days or less (from 14 days) for newborns
23.0	9/13/21	New Sections Added	Professional Services Ambulatory Surgical Treatment Centers Therapy Providers Durable Medical Equipment
23.0	9/13/21	Appendix H	Revised BCCHP sample recoupment letter
23.0	9/13/21	Appendix J	Added new appendix
23.0	9/13/21	XXI. HCBS Waiver Providers 837P Submission Guidelines	Corrected information for Box 33B inputs
23.0	9/13/21	XXIV. School-based/Linked Health Centers E. Covered Services	Added required modifiers for behavioral health service billing
23.0	9/13/21	XXIII. Pharmacy D. Billable Services vi. Drug Wastage	Added language regarding 340B Purchased Drugs

Version	Date	Section Modification	Description
22.0	4/16/2021	XXIII. Pharmacy Providers D. Billable Services	Release 22 Addition of Plan Bin/PCN GroupID information
22.0	4/16/2021	Aetna Better Health updates	Release 22 Revised billing guide to update all IlliniCare information/links to Aetna Better Health information
22.0	4/16/2021	New Sections Added	Release 22 School-based Health Centers Birthing Centers Specialized Mental Health Rehabiliation Facilities (SMHRFs)
22.0	4/16/2021	New Appendix Added	Release 22 Billing guidance on Administrative Days added as Appendix I
22.0	4/16/2021	Transportation	Release 22 Updates include: • 4/1 transition of emergency transportation claims to FFS billing to HFS • MLTSS secondary payment guidance
22.0	4/16/2021	IX. Skilled Nursing Facilities F. Billing Requirements 3. Billing Cycle	Release 22 Clarification on MLTSS billing for Medicare-covered services
21.0	1/13/2021	IV. Claim Disposition B. Provider Type vi. Overpayments/Recoupments	Release 21 Clarification of BCBSIL policy
21.0	1/13/2021	XIX. SUPR (Substance Use Prevention and Recovery) C. Code Requirements iv. Interim Claims	Release 21 Removed 30-day increment and changed to 'monthly increments'
21.0	1/13/2021	XIV. Transportation Services D. Billable Services vi. Physician Certification Statement (PCS) viii. Transportation Vendors	Release 21 Change in Molina Healthcare Transportation Vendor with updated contact information/instructions
21.0	1/13/2021	VI. Inpatient Hospital	Release 21 Added guidance on billing for Long-Acting Reversible Contraceptives (LARCs) in the inpatient setting
21.0	1/13/2021	VII. Custom Orthotic, Prosthetic and Pedorthic Services	Release 21 Added updated information on billing for quantity limits and billing for pairs
21.0	1/13/2021	XI. Federally Qualified Health Clinics, Rural Health Centers and Encounter Clinics	Release 21 Changes to allowable POS Changes to Aetna Better Health (IlliniCare) claim instructions
21.0	1/13/2021	New Sections Added	Release 21 Vision Services Pharmacy Services
20.0	9/4/2020	XIX. SUPR (Substance Use Prevention and Recovery) Services C. Code Requirements iii. Institutional Claims (837I)	Release 20 Added item 'a' under number 8, regarding Value Code 80 for SUPR providers. a: if a member is discharged on the same day as admission, the 'Statement From' and 'Statement Through' date can be the same or equal and the Value 80 submitted on the claim should be equal to 1 with the appropriate line level revenue code and procedure code.

Version	Date	Section Modification	Description	
20.0	9/4/2020	VI. Inpatient Hospital (General Acute Care and Children's Hospital) C. Coding Guidance iv. Covered and Non-Covered Days	Release 20 Clarity received from HFS for MCOs in August 2020: HFS does allow providers to submit Statement Covers Period in FL 6 equal to the same dates (same 'Statement From' and 'Statement Through' date) on claims with one accommodation revenue code and the appropriate Value 80 or 81 equal to 1.	
19.0	8/5/2020	XIV. Transportation Services D. Billable Services vii. Specific Claim Requirements	Release 19 Added updated language regarding reporting mileage to D. vii – Specific Claim Requirements	
19.0	8/5/2020	New Sections added	Release 19 Home and Community Based Health (HCBS) Waiver Providers	
19.0	8/5/2020	Section V. Outpatient Hospital	Home Health Care (HHC) Release 19 Updates made to the Outpatient Hospital Section based on HFS' Provider Notice 'Hospital Professional Billing Transition to the Outpatient Institutional Claim Format July 1, 2020' 'that includes a new topic in the section called 'Single Taxonomy and Multiple HFS Category of Service Clarity'.	
18.0	7/28/2020	Appendix G: Ordering, Referring, Prescribing (ORP)	Release 18 Updated ORP guidance for the 7/1/2020 HFS EAPG Changes Related to HFS Provider Type 30-Hospitals 31- Psych Hospitals and 32 Rehab Hospitals. Added additional specifics for HFS provider types 012- Optometrists and 013- Podiatrists related to ORP.	
18.0	7/28/2020	XIX. SUPR (Substance Use Prevention and Recovery) Services C. Coding Requirements	Release 18 Added clarity that MAT services is a weekly event.	
18.0	7/23/2020	Appendix Section added	Release 18 Added Sample MCO Recoupment Letters	
18.0	7/23/2020	New Section added	Release 18 Added vi. Overpayment/Recoupment to IV. Claim Disposition	
17.0	7/8/2020	Section V. Outpatient Hospital F. Hospital Billing Scenarios	Release 17 Added Scenario 2B for IlliniCare specifications	
16.0	4/29/2020	IV. Claim Disposition B. Provider Type v. Claim Dispute	Release 16 Updated the Process Requirements by MCO chart	
15.0	4/22/2020	New Section added	Release 15 SUPR (Substance Use Prevention and Recovery)	
15.0	4/22/2020	VI. Inpatient Hospital (General Acute Care and Children's Hospital) C. Coding Guidance ii. Value Codes	Release 15 Removed Molina from the Value Code 81 Added Molina to the MCO condition codes	
14.0	3/31/2020	New Sections added	Release 14 Dental Psychiatric Free-Standing Hospitals Rehabilitation Hospitals Long Term Acute Care Hospitals (LTAC)	

Version	Date	Section Modification	Description
14.0	3/31/2020	Section XIII. Community-Based Behavioral Services C. Coding and Billing Guidance	Release 14 Updates/corrections to Billing Scenarios
14.0	3/31/2020	Section IV. Claim Disposition V. Claim Dispute	Release 14 Blue Cross Blue Shield: Process Requirements by MCO update. Dispute submission by portal is not available.
14.0	3/31/2020	Section V. Outpatient Hospital D. Non-APL billing	Release 14 Updates to Non-APL billing: Billing of laboratory services and placement of hospital taxonomy/NPI on claim forms
13.0	1/7/2020	New Section added	Release 13 Transportation Services
13.0	1/7/2020	Section X. Hospice F. Patient Credit File Section IX. Long term Care/Skilled Nursing Facility E. Patient Credit File Section VIII. Supportive Living Facility E. Patient Credit File	Release 13 HFS Policy Change effective 12/1/2019 - MCO's no longer required to accept MEDI Screenshots.
13.0	1/7/2020	Section VI. Inpatient Hospital (General Acute Care and Children's Hospital) D. Other Abortion Condition Code	Release 13 Effective 11/1/2019 the submission of abortion claims has changed. All abortion claims for services need to be submitted to HFS directly. This pertains to both Health Choice Illinois members and traditional fee for service members. Details can be found here.
12.0	12/9/2019	Section X. Hospice G. Value Codes	Release 12 Form locator code 81: Taxonomy Codes: Hospice Non-Hospital Community (bill type 081x) = 251G00000X Hospice Inpatient (bill type 082x) = 315D00000X
11.0	10/31/2019	Appendix Section added	Release 11 Appendix G: Ordering, Referring, Prescribing (ORP)- National Provider Identifier (NPI) Requirements
10.0	10/10/2019	Appendix Section added	Release 10 Appendix F: Hysterectomy (HFS 1977) and Sterilization (HFS 2189) Memo and Forms
10.0	10/10/2019	New Section added	Release 10 CBS (Community Based Behavioral Services)
9.0	9/30/2019	New Section added	Release 9 Pediatric Services
9.0	9/30/2019	New Section added	Release 9 Federally Qualified Health Centers, Rural Health Centers and Encounter Rate Clinics
8.0	9/18/2019	Section IV. Claim Disposition iv. Corrected/Replacement Claims a. Timeframe for submitting corrected/replacement claims	Release 8 The timeframe for submitting corrected/replacement claims is 180 days from date of service or date of discharge, whichever is later.
7.0	9/3/2019	New Section added	Release 7 Hospice
7.0	9/3/2019	Section VI. Inpatient Hospital (General Acute Care and Children's Hospital) C. Coding Guidance v. Interim Claims	Release 7 Interim claims should be billed in one-month increments

Version	Date	Section Modification	Description
6.0	7/8/2019	New Section added	Release 6 Long-term Care/ Skilled Nursing Facility
5.0	6/20/2019	New Section added	Release 5 Claim Disposition
4.0	5/29/2019	New Section added	Release 4 Supportive Living Facility (SLF)
3.0	5/14/2019	New Section added	Release 3 Custom Orthotic, Prosthetic and Pedorthic Services
2.0	3/27/2019	New Section added	Release 2 Inpatient Hospital (General Acute Care and Children's Hospital)
1.0	2/19/2019	Initial IAMHP Manual created	Release 1 Overview Claims section and Outpatient Hospitals

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I. MCO Key Plan Contacts

The manual is meant to serve as a general guide for billing and claims processing policies and procedures. For any MCO-specific questions or clarifications, contact the plan directly. The links below provide contact information for each plan.

Aetna Better Health® of Illinois	Call Provider Services at 866-329-4701 or email ABHILProviderRelations@Aetna.com. To find your Aetna Better Health of Illinois Representative, please refer to PR Assignment Listing
Blue Cross Community Health Plan (BCCHP)	To find your designated point of contact, please refer to the Government Provider Network Consultant List. For more detailed information, you can contact Provider Services at govproviders@bcbsil.com or call 855-653-8126.
County Care Health Plan	Call Provider Customer Service at 312-864-8200 , Option 6 or email providerServices@countycare.com .
Meridian	Call Meridian Customer Service at 866-606-3700 or email providerhelp.il@mhplan.com.
Molina Healthcare	To find your Molina Provider Network Manager click <u>here</u> or call Provider Services at 855-866-5462 .

Provider Escalation Process

The chart above highlights general MCO contact information. There may be occasional situations that require additional support from the MCO. The Illinois Association of Medicaid Health Plans (IAMHP) maintains up to date key contact information for all the MCOs. You can access that information by clicking here.

If you have thoroughly attempted to resolve your outstanding issue or concern directly with an MCO and you cannot reach resolution utilizing the plan process, you may contact the HFS Provider Portal. The provider portal was created for providers to submit complaints to HFS about issues you are experiencing with Illinois Medicaid Managed Care Organizations (MCOs) in an electronic and secure format. The portal can be accessed by clicking here. As a reminder, the portal requires that providers first work directly with the MCO prior to submitting a MCO complaint.

II. Minimum Claim Requirements

All Illinois Medicaid MCOs are required by Federal and State regulations to capture specific data regarding services rendered to Medicaid members. It is important that providers adhere to all billing requirements to ensure timely processing and payment of claims, and to avoid unnecessary rejections and/or denials. Illinois MCOs follow the CMS (Centers for Medicare and Medicaid Services) billing requirements, except in those instances where Illinois HFS (Healthcare and Family Services) policies differ, in which case HFS guidelines will supersede the CMS requirements. The Manual incorporates and indicates those differences where applicable. It is important that all the

MCOs have accurate and up-to-date provider information on file to ensure timely claims processing. The minimum basic claims requirements are outlined below.

A. IMPACT

All Medicaid providers MUST be registered through HFS' IMPACT system and have an HFS Medicaid Provider ID number. Claims will not be processed for services rendered prior to the effective date of an IMPACT enrollment. Dates of service and IMPACT effective dates need to match for a claim to process. Providers who provide service prior to their IMPACT effective date cannot be guaranteed payment. A change in ownership or corporate structure which necessitates a new federal tax identification will terminate the participation of the enrolled provider in IMPACT. Participation and approval in IMPACT is not transferrable and providers will need to re-enroll. Claims submitted by a new owner using the prior owner's assigned Medicaid ID number will not be accepted.

IMPORTANT NOTE:

1. Providers need to enroll in IMPACT for the corresponding Provider Type and Category of Service for any services they intend to render to an MCO patient. If providers intend to render services under multiple Provider Types, they need to enroll for separate Medicaid IDs using unique, separate NPI numbers per Provider Type.

2. Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to a MCO, via the specialties and subspecialties registered in HFS Provider IMPACT system is critical to accurate claims payment. If the appropriate specialty or sub-specialties is not registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the **Provider Information Sheet** provided by HFS.

B. NPIs and TINs

Every claim must identify the name and corresponding National Provider Identification number (NPI) as well as Tax Identification Number (TIN) for the health facility or health professional that provided the treatment or service. Always ensure that the NPI and TIN used on the claim correspond to the actual provider or site of care. Incorrect NPIs/TINs and/or NPIs and TINs that do not match are two of the most common reasons that claims are denied. If you are an atypical provider (i.e. a waiver services provider), submit using your TIN and your HFS Medicaid number.

Below are the most common billing guidelines by provider type. Be sure to consult the applicable section of the IAMHP Comprehensive Billing Manual for specific requirements for your specific HFS provider type.

• FOR PROFESSIONAL CLAIMS – CMS 1500: Provider TINs are required on Field 25 on a professional claim, and the NPI should be inserted in the rendering provider field (Field 24J) and the billing field (Field 33).

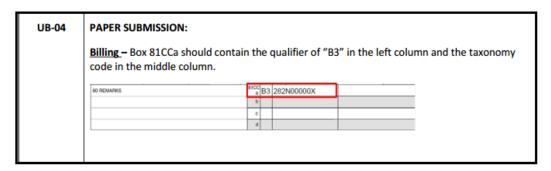
• FOR FACILITY/INSTUTIONAL CLAIMS – UB-04: Provider TINs are inserted in Field 5 and the facility NPI should go in Field 56. Individual provider NPIs are required situationally in Fields 76 through 79 (will vary depending on services performed).

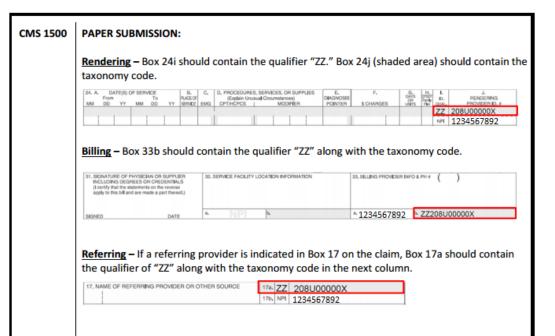
C. Provider Types / Category of Service / Taxonomy Codes

All claims must include the 10-character specific provider taxonomy code (e.g. 207Q00000X for Family Practice, 282N00000X for General Acute Care Hospital) to be processed. Information and listings of provider taxonomy codes are available by clicking here.

The taxonomy code used must match a corresponding Category of Service (COS), Procedure Code (PC) and/or Place of Service (POS). A crosswalk of taxonomies with COS, PC and POS is available here.

Examples on where to place the taxonomy code on the UB-04 and the CMS 1500 are noted below.





IMPORTANT NOTE:

Hospitals with separate NPIs for professional categories of service and institutional categories
of service must use the appropriate NPI that matches the corresponding Medicaid ID (i.e. use
your institutional NPI with your institutional Medicaid ID).

 Always ensure that if you have multiple NPIs and IMPACT Medicaid IDs that they match on the claim. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, etc.

III. General Claim Submission Guidelines for All Providers

A. Purpose

The purpose of this section is to supply all providers with the general information required to submit a claim to the MCO. **IMPORTANT NOTE:** Providers should always bill with their usual and customary charges.

B. Provider Type

This section applies to all Provider Types.

C. Coding Guidelines

i. General Coding Information

Providers must submit claims using the most current version of ICD-10 CM, CPT4, and HCPCS Level II for the date of service was rendered, in accordance with federal and state guidelines.

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment.

- Submit professional claims with current and valid CPT4, HCPCS, or ASA codes and ICD-10 codes.
- Submit dental claims with current and valid ADA codes.
- Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable),
 ICD-10 codes and DRG codes (when applicable).

Claims will be rejected or denied if billed with.1:

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-10 CM code missing any 4th, 5th, and 6th character requirements and 7th character extension requirements.

ii. Modifiers

Pricing modifiers are added to procedures listed in the Medicaid fee schedule to affect a procedure codes pricing, to indicate that a service has been altered in some way by a specific circumstance, or to identify or distinguish a service. All Illinois MCOs generally follow National

¹ This is not intended as an exhaustive list of requirements that can cause claim rejection or denial.

Correct Coding Initiative (NCCI) guidelines unless otherwise specified by HFS. Ensure that all appropriate modifiers are included on submitted claims. A link to recognized modifiers can be found here.

D. Type of Claim Submission

All claims must be filed on either:

- an original CMS1500 (red form) or UB-04; or ADA Dental 2019 Claim Form; if filing paper claims;
- an 837P or 837I if filing electronically;
- an 837D for dental claims if filing electronically; and/or
- an NDCDP electronic format for pharmacy claims.

Providers should always verify that the member was eligible and enrolled in the named MCO on the date(s) of service through either the MEDI system or MCO portal. For information regarding online claim submission please see Provider Portal - Online Claim Submission.

All submitted claims must:

- Identify the name and appropriate TIN number of the health professional or facility that provided treatment or service, with a matching NPI number based on the billing guidance for the IMPACT provider type.
- Identify the patient (RIN and/or MCO-specific Plan ID, address and date of birth)
- List the date (mm/dd/yyyy) and place of service
- If necessary, include any applicable prior authorization number provided by the MCO.
- Have valid Diagnosis, Procedure, Modifier and Location Codes
- Ensure all Diagnosis Codes are to their highest number of digits available (4th, 5th, and 6th character requirements and 7th character extension requirements).
- Ensure all other insurance resources (e.g. Medicare or other third-party coverage) have been
 exhausted before submission. Include any coordination of benefit (COB) documentation (e.g. a
 copy of the primary insurance EOB including pages with run dates, coding explanations and
 messages) with the claim submission. Medicaid is always the payer of last resort.
- Be certified by the provider that the claim:
 - o is true, accurate, prepared with knowledge and consent of provider,
 - o does not contain untrue, misleading, or deceptive information
 - identifies each attending, referring, or prescribing physician, dentist or other practitioner

i. Electronic Claim Submission

Required Data Elements

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24
 to 48 hours from the time it is sent to the time it is received. This enables providers to easily
 track their claims.
- Validation of data elements on the claim format. By the time a claim is successfully received
 electronically, information needed for processing is present. This reduces the chance of data
 entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally
 processed quicker. Reports have shown that a significant percentage of EDI claims are
 processed within 10 to 15 days of their receipt.

There are two types of modifiers:

- Level 1 modifiers are those included with CPT codes and updated annually by the American Medical Association (AMA). Definitions and the use of Level 1 modifiers can be found in the annual edition of the CPT manual. CPT information and resources can be found here.
- Level 2 modifiers are used with HCPCS codes and are recognized nationally. They are updated annually by CMS. Level 2 modifiers are found in the annual edition of the HCPCS procedure manual.

IMPORTANT NOTE: Modifiers are specific for different provider types and fee schedules. Please follow National Correct Coding Initiative guidelines, unless otherwise specified by HFS. More information and resources can be found here.

ii. Code Editing and Auditing

MCOs use code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifiers, and place of service codes against rules that have been established by the American Medical Association (AMA), Center for Medicare and Medicaid Services (CMS), public-domain specialty society guidance, clinical consultants, and the State of Illinois. Claims billed in a manner that does not adhere to these standard coding conventions will be denied.

Code editing software contains a comprehensive set of rules, addressing coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures.

The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) the software utilizes the CPT Manuals, CPT Assistant,
 CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/ column 2, mutually exclusive and outpatient code editor (OCE edits).
 In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

How to Start:

- First, the provider will need specific hardware/software requirements. There are many assorted products that can be used to bill electronically. As long as you have the capability to send EDI claims, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.
- Second, the provider needs to contact their clearinghouse and confirm they will transmit the
 claims to one of the clearinghouses used by the MCOs with which they are contracted.
 Providers must also confirm with their clearinghouse the accurate Payor ID for the MCOs. A
 table showing the clearinghouses use by each MCO, as well as their Clearinghouse Payor IDs
 is included below.
- Last, the provider needs to verify with each MCO that their provider record is set up within the MCOs claim adjudication system.

All Illinois MCOs require the ANSI X12N 837 format, version 5010A (or its successor) for EDI claim submission. Providers must use the HIPAA-compliant 837 electronic formats, or a CMS1500 and/or UB-04 or ADA Dental 2019 claim form, if filing paper claims.

Claims transmitted electronically must contain all the same data elements identified within the General Claims Submission section of the Manual.

Clearinghouse Information by MCO

Contact the clearinghouse you intend to use and determine if they require additional data record requirements.

мсо	Clearinghouse	Payor ID	Resources/Notes
Aetna Better Health® of Illinois	Multiple Click <u>here</u> for listing	68204	Contact info for the clearinghouses can be found here .
Blue Cross Community Health Plan (BCCHP)	Availity	MCDIL	To register with Availity or learn more about services available to BCBSIL providers, please visit the Availity website, or call Availity Client Services at 1-800-AVAILITY (282-4548).
County Care Health Plan	Change HealthCare	06541	Contact info for the clearinghouses can be found here .
Meridian	Availity Change Healthcare Payer Path Relay Health SSI Group	13189	Contact info for the clearinghouses can be found here .
Molina Healthcare	Change HealthCare	20934	Contact Provider Services at 1-855-866-5462 Medicaid providers, press 1

Electronic Claim Flow Description & Important General Information

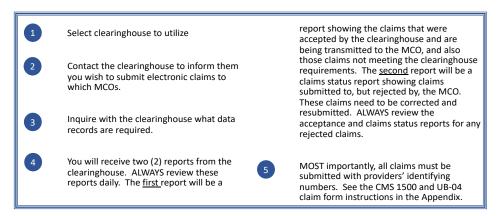
To send claims electronically to an MCO, all EDI claims must first be forwarded to the MCO's clearinghouse. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse. Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and MCO specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender, and accepted claims are passed on to the MCO. The clearinghouse will send an acceptance report² back to the provider showing which claims were rejected and which were accepted into the MCO claims system. It is very important to review this report daily to identify any claims that were not transmitted to the MCO. If errors are noted, correct and resubmit those claims. Once claims are accepted into the MCO system, they are then validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or directly to provider). It is very important to review this claims status report ² daily. The report will show all rejected claims and these claims need to be reviewed, corrected, and resubmitted timely. Claims passing eligibility requirements are then passed to the claim processing queues. <u>Providers</u> are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to the MCO.

² The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, contact your clearinghouse or vendor customer service department. Rejected electronic claims may be resubmitted electronically within timely filing deadlines (see Timely Filing Deadlines section of this Manual) once the error has been corrected. It is important that providers review the acceptance and claims status reports received from the clearinghouse to identify and re-submit these claims accurate.

IMPORTANT STEPS TO SUCCESSFUL EDI SUBMISSION



EDI Exclusions

Certain claims are excluded from electronic billing. At this time, these claim records must be submitted on paper.

Excluded Claim Categories:

- · Claim records requiring supportive documentation or attachments
- Claim records billing with miscellaneous codes
- Claim records for medical, administrative or claim reconsideration or dispute requests
- Claim requiring documentation of the receipt of an informed consent form
- Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). Provider is required to submit the invoice with the claim.
- Claim for services requiring clinical review (e.g. complicated or unusual procedure). Provider is required to submit medical records with the claim.
- Claim for services needing documentation and requiring Certificate of Medical Necessity oxygen, motorized wheelchairs.

iii. Paper Claim Submission

General Dos and Don'ts

Although electronic or online claim submission is highly encouraged, providers may submit paper claims. To facilitate processing and minimize the chances of rejection follow the following guidelines.

DOs

- Only use the original billing forms (e.g. CMS 1500 red and white form). Black and white, photocopied or other copies cannot be accepted for payment.
- Ensure claim is computer generated or typed out in a 12-point Time New Roman font (recommended). In no case should the font be smaller than 10-point.
- Ensure claims information remains within the outlines of the data fields. Information that extends beyond the box may cause the claim to be rejected.
- Submit all claims in a 9"x12" or larger envelope.
- Include all other insurance information (policy holder, carrier name, ID number and address) when applicable.
- Make sure the claim is legibly signed and dated in black ink by the provider or his or her authorized representative.³ Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable.

DON'Ts

- Submit black and white, photocopied or other facsimiles of the original red and white form.
- Submit a claim with multiple members on a single claim. Each member requires a separate claim.
- Handwrite the billing form.
- Use colored ink, highlights, italics, bold or script text.
- Use rubber signature stamp
- · Use any staples.
- Circle any data or add any extraneous information to any claim form field.
- Submit forms by fax.

Address Submission Information by MCO

Aetna Better Health® of Illinois	Aetna Better Health of Illinois P.O. Box 66545 Phoenix Az, 85082-6545
Blue Cross Community Health Plan (BCCHP)	Blue Cross Community Health Plans c/o Provider Services P.O. Box 3418 Scranton, PA 18505
County Care Health Plan	County Care Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Meridian	Meridian ATTN: CLAIMS DEPARTMENT 1 Campus Martius, Suite 720 Detroit, MI 48226
Molina Healthcare	Molina Healthcare of Illinois PO Box 540 Long Beach, CA 90801

³ An authorized representative may only be a trusted employee over whom the provider has direct supervision daily and who is personally responsible to the provider daily. Such representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service.

iv. Provider Portal - Online Claim Submission

Some MCOs provide for online claims submission through their individual plan provider portals. Providers must register for provider portal access with each MCO separately:

Aetna Better Health® of Illinois	Click here (https://medicaid.aetna.com/MWP/login.fcc)
Blue Cross Community Health Plan (BCCHP)	To register with Availity or learn more about services available to BCBSIL providers, please visit the <u>Availity website</u> , or call Availity Client Services at 1-800-AVAILITY (282-4548).
County Care Health Plan	Click here (https://countycare.valence.care/ https://countycare.valence.care/ https://countycare.valence.care) or email ProviderServices@countycare.com and ask to have a PR Rep assist you with set up.
	Providers can review and check claims, but online submission is not yet available.
Meridian	Click here (https://corp.mhplan.com/en/provider)
Molina Healthcare	Click here (https://provider.molinahealthcare.com/provider/login)

E. Additional Claim Information

i. Timely Filing Requirements by MCO

It is important that claims are submitted according to each MCOs timely filing deadlines. **PROVIDERS SHOULD NEVER HOLD CLAIMS.** Below are the MCO original claim/first time claim timely filing guidelines. Timely filing requirements for corrected or appealed claims can be found in the Claim Disposition section of the manual.

Aetna Better Health® of Illinois	A clean claim will be considered for payment only if it is received by Aetna Better Health® of Illinois no later than 180 days from the date of service.
Blue Cross Community Health Plan (BCCHP)	Providers are required to submit all claims eligible for reimbursement within 180 days from the date of service.
County Care Health Plan	Original claims must be submitted to CountyCare Health Plan within 180 calendar days from the date services were rendered or compensable items were provided.
Meridian	In-network providers have 180 days from the date of service or date of discharge to submit an initial claim.
Molina Healthcare	Providers must submit claims within 180 calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services.

ii. Electronic Funds Transfer (EFT) Payment

EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account and you receive Electronic Remittance Advices (ERAs) for easier tracking.

Additional benefits include:

Accelerated access to funds with direct deposit into your existing bank account

- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow there is an option to have ERAs routed to your existing clearinghouse.

To register for no-cost EFT/ERA service, the appropriate MCO EFT partners and/or instructions are listed below. Registration can be done quickly and easily on-line.

Aetna Better Health® of Illinois	Optum: Register using Optum's enhanced provider registration process at http://www.changehealthcare.com
Blue Cross Community Health Plan (BCCHP)	Enroll online – <u>click here</u> or complete the forms linked here: • <u>Electronic Funds Transfer Agreement</u> • <u>Electronic Remittance Advice Enrollment Form</u> • <u>Electronic Remittance Advice Enrollment Form</u>
County Care Health Plan	INSTAMED: There are two options for registering for EFT/ERA: • Online: visit www.instamed.com/eraeft • Paper: Complete this form and fax it to 877-755-3392. Contact InstaMed directly at 866-945-7990 or connect@instamed.com with any questions. CHANGE HEALTHCARE: CountyCare also provides ERA through Change Healthcare. For the initial ERA enrollment set-up with Change Healthcare, please visit Change Healthcare's Enrollment webpage directly. If you currently work with a different clearinghouse for your Electronic Claims Submission, your clearinghouse would work directly with Change Healthcare to set up ERA. You can access the ERA enrollment form by clicking here . If you or your clearinghouse have any questions regarding the ERA enrollment process or form completion, please contact Change Healthcare Provider Support at 877-363-3666 and follow the appropriate prompts.
Meridian	Complete this form and submit via secure fax to 312-980-2381. Scan and email to providerhelp.il@mhplan.com. Mail to: Meridian Attn: Provider Services 1 Campus Martius, Suite 700 Detroit, MI 48226
Molina Healthcare	Molina partners with Change Healthcare Provider Net for electronic payments and remittance advices. Change Healthcare registration instructions (link) Questions can be directed to Change Healthcare Provider Services at: wco.provider.registration@changehealthcare.com_or By phone at: 1-877-389-1160

iii. Prior Authorization

Prior authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require authorization are identified by each MCO and may differ. Emergency Room (ER) and urgent care services **never** require prior authorization. Providers should notify the MCO of post-stabilization services. Notification and clinical information are required for ongoing care and authorization of the services. Failure to obtain authorization may result in administrative claim denials.

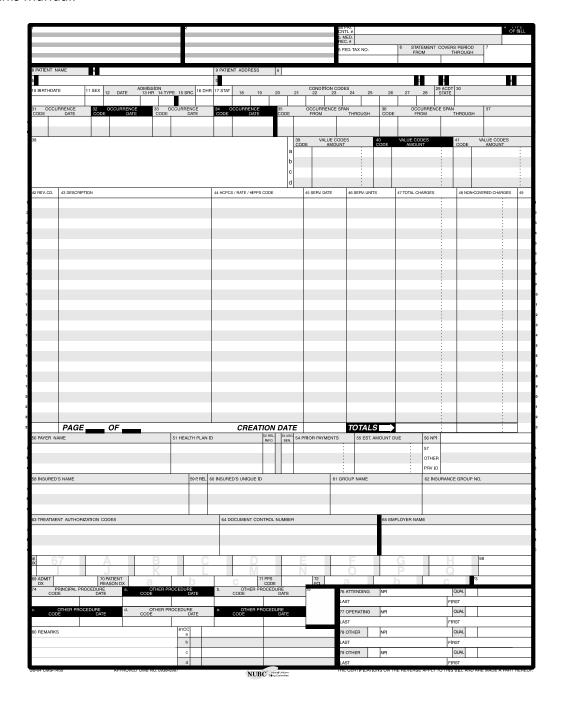
The table below indicates by MCO prior authorization information for inpatient, outpatient and behavioral health services.

мсо	Is an Authorization Required?	How to submit an Authorization?
Aetna Better Health® of	Prior Auth Tool: (<u>link)</u>	Provider Portal: https://medicaid.aetna.com/MWP/login.fcc
Illinois		Fax: 877-779-5234
		Authorization Form: (link)
		Phone: 866-329-4701
Blue Cross Community	Summary list can be found <u>here</u> .	Phone: 877-860-2837
Health Plan (BCCHP)	Detailed procedure code listing	Physical Health Fax: 312-233-4060
	(<u>link</u>)	Behavioral Health Fax: 312-233-4099
		Medicaid Preauthorization Form:
		Physical Health (<u>link</u>)
		Behavioral Health (<u>link</u>)
		**For outpatient services only, please see Behavioral Health
		authorization forms**
		Provider Portal (link)
		Portal Enrollment (link)
County Care Health Plan	CPT Code List: (<u>link</u>)	Provider Portal: (link)
		Phone: Medical 312-864-8200
		711 TTD/TTY Option 4
		Fax Inpatient Medical Prior Authorization Form to: 800-856-9434
		Phone: Behavioral Health: 312-864-8200
		711 TTD/TTY Option 4
		Fax BH Authorization Form to: 800-498-8217
Meridian	Prior Auth Requirements	Provider Portal: (link)
	Summary List: (<u>link</u>)	Fax: 312-508-7299
		Authorization Form: (link)
		Phone: 866-606-3700
Molina Healthcare	Code List by Quarter/Year: (link)	Provider Portal: (<u>link</u>)
		Fax: 866-617-4971
		Authorization Form: (link)
		Phone: Molina's Health Care Services Department at 855-866-5462
		Mail:
		Molina Healthcare of Illinois
		Attn: Health Care Services Dept.
		1520 Kensington Road Suite 212
		Oak Brook, IL 60523

F. Sample Claim Forms

i. UB-04:

MCOs follow the <u>UB-04 specification manual</u> as publish by NUBC except for exceptions noted in this manual.



ii. Sample CMS 1500 Form

MCOs follow the CMS 1500 Reference Instruction Manual published by the NUCC committee, except for exceptions as noted in this manual.

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iii. Sample ADA Claim Form

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ľ	ADA American Dental Association® Dental Claim Form HEADER INFORMATION																		
		Pype of Transaction (Mark all applicable boxes)						\dashv											
	Statement of Actual Services Request for Predetermination/Preauthorization																		
	EPSDT / Title XIX								-		nen/o							т	
	2.1	Predetermination/Preauthorization Number								POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)								-	
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	0					16. Plan/Group Number 17. Employer Name													
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		Plan/Group Number 10. Patient's Relationship to Person named in #5						20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code											
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		charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all								(Use "Place	of Service	e Codes for Pr	ofessional Claim	is")					
		as a position of such charges. To the extent permitted by law I consent to your upp and disclosure.						40. Is	40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM							(MM/DD/CCYY)	1		
	Х	or my providuced nearin information to carry out payment activities in connection with this cla							No (3klp 41-42) Ye			es (Complete 41-42)							
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		to the below named dentist	hereby authorize and direct payment of the dental benefits otherwise payable to me, directly of the below named dentist or dental entity.						45. TI	45. Treatment Resulting from									
	х								Occupational illness/injury Auto accident Other accident										
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	48.	Name, Address, City, State, Zip Code						m	multiple visits) or have been completed.										
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	52.	Phone () - 52a. Additional Provider ID 5						57. Phone () - 58. Additional Provider ID											
	2019 American Dental Association							To reorder call 800.947.4746											
	J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)											0	r go online at	ADAcatalog.or	g				

IV. Claim Disposition

A. Purpose

The purpose of this section is to outline policies and procedures related to a claim dispositions.

B. Provider Type

The Claim Disposition Section applies to all provider types.

i. Clean Claim

A **clean claim** is a claim submitted on the proper form, to a health plan for an eligible member, by a provider authorized to perform a covered benefit that is medically necessary and appropriate, where no additional information is required to process the claim. HFS has established processing requirements for all MCOs related to clean claims. These requirements are: 90% of clean claims must be processed within 30 days and 99% of clean claims must be processed within 90 days. It is important to note that the requirements are for claims processing also known as claims adjudication. Claims processing/adjudication does not mean payment is necessarily made. It does mean that a determination has been made as to the outcome of the claim process. Those determinations can include pending the claim, denying the claim or claims payment.

ii. Claim Rejections

A claim rejection occurs **prior to the claim processing for payment**. A rejected claim is most often related to input errors or invalid data.

There are two places that a claim rejection can occur:

- 1. Direct from the provider clearinghouse and
- 2. Through the clearinghouse from the MCO. In both instances providers are notified by the clearinghouse.

Requirements are established by the MCO for the clearinghouse. Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and MCO specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender. The clearinghouse will send an **acceptance report**⁴ back to the provider showing which claims were rejected and which were accepted into the MCO claims system. It is very important to review this report daily to identify any claims that were not transmitted to the MCO. If errors are noted, fix the errors and either submit a new claim or a corrected/replacement claim. See information on timeframes and resubmission/corrected/replacement claims processes below.

It is important to note that since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse **are not transmitted to the MCO**. Once claims are **transmitted and accepted into the MCO system**, they are then validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back daily to the clearinghouse. The

⁴ The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse.

clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or directly to provider).

It is very important to review this **claims status report**⁵ daily. The report will show all rejected claims and these claims need to be reviewed, corrected, and resubmitted timely. Providers are responsible for verification of EDI claims receipts.

Claims that are rejected are not typically housed in the MCO claims systems. In most cases, the **MCO will not have record of the claims** as the claim has not passed to the claim processing queues. Therefore, the timely filing rules (180 days from date of service) would still be in effect and the provider will need to correct the claim and resubmit it as a new claim within 180 days from the date of service.

a) Common Claim Rejection Causes

Claims may reject for a number of reasons. Below are some common rejections that occur and why. This is not an all-inclusive list but will provide direction on certain circumstances to avoid. Many of these rejection reasons have been addressed throughout previous sections of this manual.

Common Rejections								
Member DOB missing from the claim.	DOS Prior to Effective Date of Health Plan or member eligibility date.							
Member Name or ID Number missing or invalid for the claim.	Incorrect Form Type used.							
Provider Name, TIN or NPI missing from the claim.	Invalid TOB or invalid type of bill.							
Claim data is unreadable due to either too light, dot matrix, or too small font.	No Detail Service line submitted.							
Diagnosis Code missing or invalid.	Admission Type is missing.							
Rev Code missing or invalid.	Patient Status is missing.							
CPT/Procedure Code/Modifier missing or invalid.	CLIA certification missing/invalid or incomplete.							
Dates Missing from required fields . Example "statement from" UB-04 or "Service From" CMS 1500.	DOS on Claim is not prior to receipt of claim. Cannot be a future DOS.							

b) How to Correct A Rejected Claim

When a claim is rejected, review the Clearinghouse reports noted above and determine what needs to be corrected on the claim. Make the applicable correction as noted and resubmit the claim. In this instance, you do not need to follow the corrected/replacement claim guidelines. This is a **new** claim being resubmitted.

When a rejection is received proceed as follows:

- · Verify the claim data submitted is correct
- Verify with <u>your</u> clearinghouse to ensure the accurate data was sent to the MCO

⁵ The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse.

• If you believe the rejection from the clearinghouse was in error, please contact the MCO directly using the provider escalation process. Contact info for the plans is available here.

iii. Claim Denial

Denied claims are claims that the MCO has processed and deemed unpayable. These claims may violate the terms of the payor-provider agreement, authorization requirements not met, service limits or some other type of error that is only identified after claim processing has occurred. See **Explanation of Payment (EOP)** section below for how to identify why a claim was denied.

a) Explanation of Payment (EOP)

MCOs will send an Explanation of Payment (EOP) that provides details on claims that have been paid, denied or adjusted. An EOP contains information such as: Member ID, Member Name, Date of Service, Provider Name/Number, Billed Amount, Allowed Amount, Paid Amount, and Adjustment Codes/Reasons. An EOP can also be referred to as a Remittance Advice or Report.

If there is a denial noted, pay special attention to the ADJUSTMENT CODES/REASON CODES/REMARK CODES. The electronic EOP/remittance advice or report (ANSI X12N 835) uses HIPAA-compliant remark/ adjustment code/reason codes. An EOP remittance advice report sent on paper or downloaded from an MCO's provider portal may relay proprietary MCO adjustment remark and/or reason codes. These codes assist you in determining if additional action can be taken by you. In some cases, the adjustment/remark reason code may be requesting an edit to be made and then a corrected/replacement claim may be submitted. Additional documentation or information may also be requested to be submitted to the MCO. If you do not take action within the appropriate timeframe your claim will remain denied. See timeframes for submitting corrected/replacement claims by MCO below.

b) EOP Examples

Although similar information is included on the EOPs, each MCO EOP may be organized differently. Examples of EOP's by MCO are in Appendix D.

c) Obtaining an EOP

If you have submitted paper claims you will receive your EOP via mail along with the corresponding payment for services if applicable. You may also obtain an EOP electronically via each MCO's provider portal or through a vendor/clearinghouse via the ASC X12N 835 electronic transaction. Instructions for obtaining/retrieving an EOP are noted below by MCO.

мсо	How to Retrieve An EOP/Remittance/Advice Report
Aetna Better Health® of Illinois	Provider remittance advice/report can be retrieved via Aetna Better Health® of Illinois Provider Portal: Log into the Provider Portal. Click here. Select Claims icon Select payment history Select check date once your transactions list appears Select download (excel format) to export EOP or Select print to print EOP Please note: For best results, enter the date range to include at least 2 days before and 2 days after the targeted date(s). To search, enter one or more of the following search criteria on the portal. Click here. The Submission Date range you provide is limited to a one-month span. Only the last 24 months of claims data is available online.
Blue Cross Community Health Plan (BCCHP)	Provider remittance advice/report can be retrieved by following the attached instructions. Click <u>here</u> .
County Care Health Plan	Provider remittance advice/report can be retrieved via CountyCare Provider Portal: https://countycare.com/wp-content/uploads/CCR InstaMedOrderFormPayerPayments.pdf
Meridian	Providers can sign up for Electronic Remittance Advice/Report (ERA) transmission by contacting our ERA/EFT partner Payspan at payspan.com or by contacting Payformance Corporation at 877-331-7154. Providers can also sign up for the Meridian Secure Provider Portal and obtain EOPs by logging onto the portal at:. provider Portal Login (ilmeridian.com)
Molina Healthcare	Providers can retrieve the EOP/Remit from Molina's Provider portal. EOPs on the portal can be viewed up to 24 months from the remit date. If the provider is registered for EFT they are automatically registered for electronic remittance advice/report. ERAs and EFT are managed by Change Healthcare. Change Healthcare's phone # is 877-389-1160, email is wco.provider.registration@changehealthcare.com, and the website is www.providernet.adminisource.com/Start.aspx. Providers can contact Molina at EDI.ERAEFT@MolinaHealthcare.com for additional questions. Providers can also call customer service at 855-866-5462 to retrieve an EOP/Remit. Customer service will fax or email the remits to the provider. This is not the preferred method.

d) Interpreting and Understanding An EOP

EOP's contain a variety of information to assist providers in understanding claim processing. It is important for providers to understand what the EOP is communicating about a particular claim or service. To assist with the interpretation of EOPs refer to the MCO's Educational

EOP which explains each field on the EOP. Examples of the Educational EOP's by MCO are located in Appendix E.

e) Common Denial Causes

The table below highlights some of the most common denial reasons that occur. This is not an all-inclusive list but will provide direction on certain circumstances to avoid. Many of these denial reasons have been addressed throughout previous sections of this manual.

Common Denial Reasons		
Billed Charges Missing or Incomplete	Tax Identification Number (TIN) Missing or Invalid	
Diagnosis Code Missing 4 th or 5 th Digit	Date Span Billed Does Not Match Days/Units Billed	
Primary Insurers EOB (Explanation or Benefits) is Missing or Incomplete	Provider TIN and NPI Do Not Match	
Place of Service Code Invalid	Member not enrolled on DOS	
Incorrect Claim Form	Service not on HFS Fee Schedule	
Authorization not obtained		

f) Common Denial Reasons by MCO

The table below illustrates the top 5 denial reasons encountered by MCOs. In addition, following the reason is action that can be taken by the provider to potentially resolve the denial. There are multiple reasons for claim denials, below are reasons the MCOs see most frequently.

Denial Reason	Action
Not Enrolled on DOS	Verify if member was active on DOS. If member was active, submit a claim dispute. Use MEDI system to validate enrollment.
The Time Limit for Filing Has Expired	Determine if the claim was an initial claim or a corrected/replacement claim. If the claim was a corrected/replacement claim, validate that you have the appropriate type of bill.
Missing or Invalid Taxonomy	Resubmit corrected/replacement clean claim with the valid taxonomy.
Service Not Included on Fee Schedule	No action needed. Non-covered service per HFS fee schedule.
Recipient Not Eligible on Date of Service	Correct claim or validate with MEDI. Potential update may need to be done at State level.

iv. Corrected/Replacement Claims

A corrected/replacement claim is a replacement of a previously submitted and adjudicated claim. Previously submitted claims that were completely rejected are not corrected/replacement claims and should be sent as a new claim.

File a NEW Claim When	File a Corrected/Replacement Claim When
Claim never submitted.	EOP received and corrections required to the original claim. Examples include: Invalid DOS, Modifiers or CPT code edit/changes, place of service change.
Claim was rejected at the provider Clearinghouse	EOP received and the claim was denied at the MCO for a billing error.

a) Timeframe for Submitting Corrected/Replacement Claims

In the above situations, MCOs allow providers to resubmit or correct claims. The timeframe for submitting corrected/replacement claims is 180 days from date of service or date of discharge, whichever is later. A provider can resubmit a corrected claim/replacement claim as many times as necessary as long as it is within the 180 days. The timeframe to submit corrected/replacement claims is standard across all of the MCOs.

b) Submitting A Corrected (Replacement) Claim

A corrected/replacement claim must be submitted when all or a portion of the claim was paid incorrectly, or a third-party payment was received after the MCO made the payment. When a replacement claim is received, the MCO deletes the entire original claim and replaces it with the information contained on the replacement claim. All money paid on the original claim is debited and a new payment is issued based solely on information reported on the replacement claim.

When sumitting a corrected/replacement claim, you must take note of the methods in which a MCO accepts corrected/replacement claims. Those methods are summarized below. In addition, when submitting a corrected/replacement claim via paper or EDI there are specific guidelines to follow. Timely Filing guidelines remain in effect for replacement claims. Details of Timely Filing guidelines by MCO can be found here. If a corrected/replacement claim is submitted without following the process outlined below, the claim will be processed as an original claim and rejected or denied as a duplicate.

мсо	Corrected Claim Submission Methods by MCO
Aetna Better Health® of Illinois	Corrected/replacement claims can be submitted via: 1. EDI - see process/guidelines noted below 2. Paper submission – Submit to: Aetna Better Health Choice of Illinois, Attn: Corrected Claim PO Box 66545 Phoenix, AZ 85082-6545
Blue Cross Community Health Plan (BCCHP)	Corrected/replacement claims can be submitted via: 1. EDI - see process/guidelines noted below 2. Paper submission – Submit to: Blue Cross Community Health Plans c/o Provider Services P.O. Box 3418 Scranton, PA 18505
County Care Health Plan	Corrected/replacement claims can be submitted via: 1. EDI - see process/guidelines noted below 2. Paper submission – Submit to: County Care Health Plan PO Box 211592 Eagan, Minnesota 55121-2892

мсо	Corrected Claim Submission Methods by MCO	
Meridian	Corrected/replacement claims can be submitted via: 1. EDI - see process/guidelines noted below. Electronic claim submission can be done through a clearinghouse. Meridian is currently accepting electronic claims from Availity, but will accept electronic claims from all clearinghouses sent through Availity 2. Paper submission – Submit to: Meridian P.O. Box 4020 Farmingrton, MO 63640	
	3. Meridian's 's Online Provider Portal: <u>Provider Portal Log-in</u>	
Molina Healthcare	Corrected/replacement claims can be submitted via:	
	EDI - see process/guidelines noted below	
	 Paper – Please submit to: Molina Healthcare of Illinois, Inc. P.O. Box 540 Long Beach CA 90806 	
	 3. Molina Healthcare's Provider Web Portal. Click here. Web Portal Instructions: Select the radio button for the correct claim option. Enter the ID number of the claim you want to correct. Make corrections and add supporting documents explanation of benefits (EOB). Submit your claim. 	

Below are the billing guidelines for submitting corrected/replacement claims via EDI:

Submitting Corrected/Replacement EDI Claims		
CMS 1500	In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes: A. "7" – REPLACEMENT (replacement of prior claim) B. "8" – VOID (void/cancel of prior claim) The 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected, found on the remittance advice/report.	
UB04	Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the 7 or 8 goes in the third digit for "frequency." The 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected, found on the remittance advice/report.	

v. Claims Dispute

A claim dispute process allows Providers to contest a payment decision after a claim has been adjudicated.

If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information, you should submit a corrected/replacement claim through the claim submission process. You do not need to file a dispute.

If you have made reasonable attempts to correct a claim and you remain dissatisfied with the disposition (paid amount or denial), you may submit a claim dispute stating why you disagree.

Outlined below are the options for submitting a Claim Dispute Process for each MCO.

Process/Requirements by MCO

мсо	Claim Dispute Process
Blue Cross Community Health Plan	Submit via Provider Portal: Not available
(ВССНР)	2. Submit via Customer Service Line: Providers may contact BCBSIL at 877-860-2837 regarding Claim Disputes. Providers need to indicate they want to file a Claim Dispute. Providers who state they want to file a Claim Appeal will be asked to submit a signed Authorized Rep (AOR) Form. AORs are not required when filing a Claim Dispute. BCBSIL must be notified in writing within 60 days of receipt of payment. Unless the provider disputes a claim(s) payment within the time frame indicated above, prior payment of the disputed claim(s) shall be considered final payment in full and will not be further reviewed by BCBSIL.
	 Submit via Paper Form: Claim Disputes must be submitted with a completed Provider Dispute Form. The Form is located on our Provider Portal here.
	4. BCBSIL must be notified in writing within 60 days of receipt of payment. Unless the provider disputes a claim(s) payment within the time frame indicated above, prior payment of the disputed claim(s) shall be considered final payment in full and will not be further reviewed by BCBSIL.
	Mail claim disputes to: Blue Cross Community Health Plans Claim Disputes c/o Provider Services P.O. Box 3418 Scranton, PA 18505
County Care Health Plan	Submit via Provider Portal: Not available
	2. Submit via Customer Service Line: Providers may contact CountyCare Health Plan regarding claims disputes at 312-864-8200, where an OCI (Open Claim Issue) ticket is opened to Claims. Corrected/replacement claims, requests for reconsideration or claim disputes must be received within 60 calendar days from the date of notification of payment or denial.
	3. Submit via Paper Form: Providers may submit additional information to support why they believe the claim should be paid. Complete the Claim Dispute Form. Click here for the form. Written disputes/ appeals are reviewed by the Claims team. Corrected/replacement claims, requests for reconsideration or claim disputes must be received within 60 calendar days from the date of notification of payment or denial.
	Mail claim dispute to: County Care Health Plan PO Box 211593 Eagan, Minnesota 55121-28923
	 Submit via Provider Relations Representatives: Providers may work with their PR Representative who will coordinate with Claims to investigate any issues. You can find your PR Representative on www.countycare.com or Email ProviderServices@countycare.com.

мсо	Claim Dispute Process
Aetna Better Health® of Illinois	A claim dispute is to be used <u>only</u> when a provider has received an unsatisfactory response to a request for reconsideration. (Click <u>here</u> for instructions and a reconsideration form).
	1. Submit via Provider Portal: Not available
	2. Submit via Customer Service Line: Not available
	 Submit via Paper Form: Claim disputes must be submitted in writing within 90 of the original determination or Explanation of Payment (EOP) for reconsideration. The completed Claim Dispute Form (which can be found here and any supporting documentation is to be mailed.
	Mail claim dispute to:
	Aetna Better Health of Illinois
	PO Box 66545
	Phoenix, Az 85082-6545
	4. Submit via Provider Relations Representatives: Not available
Meridian	1. Submit via Provider Portal: Preferred method of disputing a claim. Disputes/reconsiderations must be submitted within 90 days from the explanation of payment (EOP) via the Meridian Secure Provider Portal. Disputes should include an explanation of the nature of the claim dispute/reconsideration and any special circumstances that you would like Meridian to consider. A Claim Dispute Form is not required but may be attached to support the dispute. Click here to access the form.
	2. Submit via Customer Service Line: Not available
	3. Submit via Paper Form: Providers should complete the Claim Dispute Form within 90 days from notification of payment explaining the nature of your dispute/appeal and any special circumstances that you would like Meridian to consider. Click here to access the Claim Dispute Form. Attach a copy of the claim and documentation to support your position, such as medical records.
	Mail claim dispute to:
	Meridian ATTN: Provider Disputes P.O. Box 4020 Farmington, MO 63640
	4. Submit via Provider Relations Representatives: Not Available
Molina HealthCare	Submit via Provider Portal: Not Available
	2. Submit via Customer Service Line: Not Available
	3. Submit via Paper Form: A Claim Dispute must be requested within 90 days of Molina Healthcare Healthcare's original remittance advice/report date. Additionally, the item(s) being resubmitted should be clearly marked as a dispute and must include the following:
	 Payment adjustment requests must be fully explained.
	 The previous claim and remittance advice/report, any other documentation to support the adjustment and a copy of the referral/authorization form (if applicable) must accompany the adjustment request.
	 The claim number clearly marked on all supporting documents

мсо	Claim Dispute Process
	 The Claims Dispute Request Form must be included and can be found here Claims Dispute Request Form. Must be submitted via fax to (855) 502-4962.
	4. Submit via Provider Relations Representatives: Not available

vi. Overpayment/Recoupments

There are occasional circumstances in which the MCO will need to request a refund or recoupment of a payment already made to a provider. Below are general processes by each MCO related to recoupments. It is important to note that some providers may have contractual arrangements with the MCOs and therefore may not follow the outlined process.

Common Recoupment Reasons

Below are common reasons for a recoupment. This is not an all-inclusive list.

Category	Recoupment Reason
Eligibility	Changes in membership due to retro or late eligibility changes
Eligibility	IL HFS IMPACT provider termination
Changes to state policy	HFS retroactive rates/fees
Fraud	OIG Fraud Waste Abuse Sanctions
MCO Processes	Retro changes to provider contract
MCO Processes	Post Payment Reviews – Paid duplicate claim

Recoupment Notification Process

Providers will be notified by the MCO if a recoupment is necessary. At a minimum the MCO will provide a remittance advice and/or a letter to providers with the following details:

- Name of the patient
- Date of service
- Service code and/or description
- Recoupment amount
- Reason for recoupment
- Details on how to initiate a claim appeal address and/or phone number
 - Any appeal must be made within 60 days from the receipt of the remittance.

- No recoupments or off-set will be requested or withheld from future payments 12 months^{6*} or more after original payment is made except for the following circumstances:
 - a court, government administrative agency, other tribunal, or independent third party arbitrator makes or has made a formal finding of fraud or material misrepresentation;
 - an insurer is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act; or
 - the provider has already been paid in full by any other payer, third party, or workers' compensation insurer

Sample Recoupment Letters are available by MCO in Appendix H.

vii. Provider Portal Claim Status Functionality by MCO

Each MCO has established a secure Provider Portal. The Provider Portal contains a variety of functionality to assist providers with various administrative requirements. Providers must first register for provider portal access with each MCO separately. The below table is a quick reference to each of the MCO links to establish access.

мсо	Provider Portal Access
Aetna Better Health® of Illinois	Click <u>here</u> (https://medicaid.aetna.com/MWP/login.fcc)
Blue Cross Community Health Plan (BCCHP)	To register with Availity or learn more about services available to BCBSIL providers, please visit the <u>Availity website</u> , or call Availity Client Services at 1-800-AVAILITY (282-4548) .
County Care Health Plan	Click here (http://www.countycare.com/providers/portal) or email ProviderServices@countycare.com and ask to have a PR Rep assist you with set up.
Meridian	Click here (https://corp.mhplan.com/en/provider)
Molina Healthcare	Click here (https://provider.molinahealthcare.com/provider/login)

⁶ CountyCare is not subject to the IL Insurance Code as they are a government entity contracted with HFS under the County Managed Care Community Network (MCCN) contract and not regulated by the Department of Insurance. CountyCare makes every effort to align with Insurance Code.

^{*} For BCCHP, the initial notification process will happen within the required 12 months and will request the provider refund the overpayment within 90 days. If the overpayment is not refunded, BCCHP will offset the refund from future payments.

PROVIDER PORTAL FUNCTIONALITY

Provider Portal Functionality	Aetna Better Health® of Illinois	Blue Cross Community Health Plans	County Care Health Plan	Meridian	Molina Healthcare	
Member Eligibility Verification	Yes	Yes	Yes	Yes	Yes	
Prior Authorization Submission	Yes	No	Yes	Yes*	Yes	
Prior Authorization Status	Yes	No	Yes	Yes	Yes	
Clinical Information Accepted for Prior Authorization	Yes*	No	Yes	Yes**	Yes	
On-line Claims Submission	Yes	No	No	Yes	Yes	
Submit Corrected/Replacement Claims	Yes	No	No	Yes	Yes	
		Claims Status Detai	ls:			
Claim Received (acknowledgement)	Yes	Yes	Yes	Yes	Yes	
Claim Status *Pending*Paid* Denied	Yes	Paid Status Only	Yes	Yes	Yes	
Reason/Adjustment/ Remark Why claim not paid?	Yes	No	Yes	Yes	Yes	
Reason/Adjustment/ Remark Code Explanation	Yes	No	Yes	Yes	Yes	
Payment Amount	Yes	Yes	Yes	Yes	Yes	

^{*} Clinical documentation can be attached in the portal

^{**} In the Meridian Portal you will be linked to an on-line electronic authorization form. This electronic submission allows for clinical documentation to be attached.

V. Outpatient Hospital

A. Purpose

The purpose of this section is to outline policies and procedures for hospitals billing for outpatient services.

B. Provider Type

This section applies to General Acute Care Hospitals.

NPIs

- Both General Acute Care and Children's Hospitals are required to register their NPIs as a Provider
 Type 30 General Acute Care Hospital for outpatient billing.
- Hospitals must bill all outpatient services under the NPI assigned for institutional services. Hospitals should not use their professional services NPI for dates of service beginning July 1, 2020. Hospitals must use the NPI associated with their outpatient Categories of Services as indicated in the IMPACT system.

Outpatient billing Categories of Service

Listed below are the allowable outpatient Categories of Service for UB-04/837I billing:

- 024 Outpatient Services (General)
- 025 Outpatient Services (ESRD)
- 027 Psychiatric Clinic Services (Type A)
- 028 Psychiatric Clinic Services (Type B)
- 029 Clinic Services (Physical Rehabilitation)

Although COS is not directly added to a claim submitted to a MCO, correct registration of specialties and sub-specialties in the HFS Provider IMPACT system is critical to accurate claims payment. If the appropriate specialty or sub-specialties is not registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by HFS.

Non-APL Categories of Service for billing for claims with dates of service PRIOR TO 7/1/2020 Listed below are the allowable outpatient Categories of Service for CMS1500/837P billing for billing dates of service prior to 7/1/2020:

- 001 Provider Services
- 011 Physical Therapy Services
- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services
- 014 Audiology Services
- 017 Anesthesia Services
- 030 Healthy Kids Services
- 040 Pharmacy Services (Legend and OTC)
- 041 Medical Equipment/Prosthetic Devices
- 048 Medical Supplies

C. Coding Guidance - EAPG Pricing

i. Ambulatory Procedures Listing (APL): Claims with Dates of Service Prior to 7/1/2020

Ambulatory services include all services that do not require an inpatient admission of a member to a hospital, including services provided in hospital outpatient departments, clinics, Ambulatory Surgical Treatment Centers (ASTCs), emergency departments, and observation units. Certain procedures provided in an outpatient or ambulatory setting that have been determined to be either unique or most appropriately provided in those settings are contained in the Ambulatory Procedures Listing (APL).

APL services generally fall into the following categories: surgical, diagnostic and therapeutic, emergency department, observation and psychiatric treatment services. A listing of current APLs can be found here. As the APL listing is updated on a regular basis, it is important to match the date of service to the correct APL list.

Effective with dates of service beginning 7/1/2014, all outpatient/ambulatory claims are grouped and reimbursed through 3MTMEAPG software, or similar MCO grouper software. MCOs use the same grouper version as HFS.

All hospital outpatient/ambulatory claims must be submitted on a UB-04 (837I) claim form and MUST include one of the following:

- A valid Ambulatory Procedure Listing (APL) procedure code, which is valid on the date of service⁷; and/or
- At least one Emergency Department (ED) revenue code with an associated HCPCS code; and/or
- At least one Observation (OBV) revenue code with any associated HCPCS codes.

Failure to have an APL code, ED revenue code, and/or OBV revenue code will result in a denial of the entire claim by the MCO.

All hospital outpatient services billed that do not meet one of the above three (3) criteria must be billed as FFS on a CMS 1500/837P with the registered professional service NPI.

See Non-APL Billing section for more detailed guidance.

Not every revenue service line on a UB-04/837I claim needs to have an HCPCS/CPT code. However, if one is reported it will be considered and weighted with all the other elements of the claim for EAPG discounting, consolidation and pricing.

Revenue codes that do not require HCPCS:

- Pharmacy (0250-0259)
- M&S supplies and devices (0270-0273, 0275-0279)

⁷ Note that if the APL code is from the <u>Series Billable list</u>, there must be an APL code present on **each date of service (claims with dates of service prior to 7/1/2020).** If it is not a series billable service, it will be considered a single episode of care.

- Anesthesia (0370-0379)
- Supplies (0620-0622)
- Recovery Room (0710, 0719)

Other pharmacy revenue codes (e.g. 026X, 063X) do require HCPCS codes with corresponding NDC codes. Refer to the NDC billing section for more details.

ii. EAPG Changes: Claims with Dates of Service equal to or greater than 7/1/2020

Beginning with dates of service of 7/1/2020, the use of APL logic is being eliminated. Hospitals are no longer required to bill as indicated in the 'NON-APL Billing Section' outlined in <u>Section D</u> of this billing section topic.

Hospitals must bill all services previously billable as professional (non-hospital) services as outpatient institutional services via an 837I electronic transaction, or for claims requiring an attachment, a UB-04 paper claim form. Hospitals must use the NPI assigned for institutional services. All outpatient services billed by a hospital provider will be billed on the 837I and reimbursed through the EAPG reimbursement system, with the exception of renal dialysis services that continue to be paid at a per diem (daily rate).

Hospitals should **not** use their professional services NPI for dates of service beginning July 1, 2020.

Hospitals must split claims containing multiple service dates that cross July 1,2020. This excludes Emergency Department Services and Observation Service claims. If a patient is held in the ER or Observation prior to 7/1/2020 and services cross this timeline, the processing will be based on the patient's admit date for the rules the biller should follow. For example, if the patient is admitted on 6/30/2020 and discharged on 7/1/2020, rules for a claim received date of 6/30/2020 should be followed.

Billing for Speech, Physical, and Occupational Therapy

If more than one type of therapy is given on the same service date, all therapy services must be billed on the same claim. All therapy billing, both evaluations and treatment, continue to require the following modifiers:

- Physical Therapy GP
- Occupational Therapy- GO
- Speech Therapy- GN

Therapy services will no longer be cross walked to a small subset of covered code. Physical, occupational, and speech therapy should be billed with the actual therapy codes. Hospitals need to use the appropriate revenue code and complete the associated fields.

If a hospital provider has HFS COS 029 associated with their IMPACT registration, the provider must bill therapy claims with one of the rehabilitation taxonomy billing code as follows:

Taxonomy	Description
273Y00000X	Rehabilitation Unit
283X00000X	Rehabilitation Hospital
283XC2000X	Rehabilitation Hospital - Children

If a hospital provider **does not have** HFS COS 029 associated with their IMPACT registration, but is attested for **HFS COS 024**, the provider must bill their therapy claims with one of the following general acute taxonomy billing codes as follows*:

	2
Taxonomy	Descriptions
282N00000X	General Acute Care Hospital
282NC2000X	General Acute Care Hospital - Children
281P00000X	Chronic Disease Hospital
281PC2000X	Chronic Disease Hospital – Children
284300000X	Special Hospital
286500000X	Military Hospital
2865C1500X	Military Hospital - Community Health
2865M2000X	Military Hospital - Medical Center
282NR1301X	General Acute Care Hospital – Rural
282NW0100X	General Acute Care Hospital - Women

Billing Under a Provider's Name and NPI (Professional Fees)

Hospitals can bill separately on a fee-for-service basis for a salaried physician providing direct patient care. These claims must be billed under the name and NPI of the practitioner who rendered the service, NOT the facility name and NPI. These services will continue to be billable on an 837P and should NOT be billed under the hospitals NPI.

A "salaried provider" includes:

- a provider who is reimbursed through the hospital through a contractual arrangement to provide direct care
- a group of providers with a financial contract to provide emergency department care
- the professional component CPT code for an ECG procedure (interpretation and report only) must be billed under the name and NPI of the practitioner performing that service.

Salaried providers in this instance does NOT include radiologists, pathologists, nurse practitioners, or certified nurse anesthetists. No separate reimbursement will be allowed for such providers.

iii. Emergency Department Services

Hospitals are required to code emergency department services with Revenue Codes 0450, 0451, and 0456 with their associated HCPCS codes from the HFS APL list for claims with dates of service prior to 7/1/2020. APL is eliminated on claims with dates of service on or after 7/1/2020. The revenue and procedure code requirements in Table 1 below remain in place for all claims regardless of dates of service. If the claim does not have one of these Rev Codes, the entire claim will be denied (missing/invalid Rev code).

TABLE 1: Revenue Codes with associated HCPCS Codes:

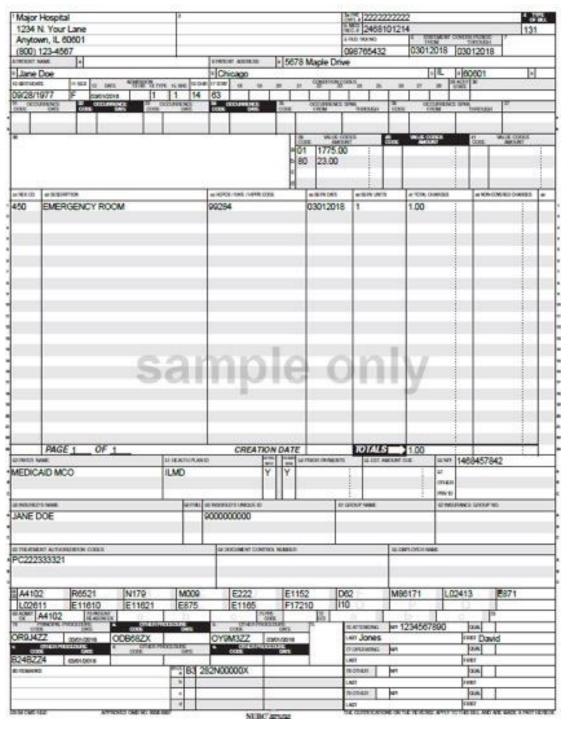
Revenue Code	Associated HCPCS Codes
0450	99284, 99285, 99291, G0383, G0384
0456	99282, 99283, G0381, G0382
0451	99281, G0380

At least one of the above Revenue Codes must be billed with an associated HCPCS code above for the claim to process. Any other ED Revenue Codes on the same claim may be billed with any valid HCPCS not from the above list.

For claims with dates of service **prior to 7/1/2020**, only one APL is required on emergency department services that cross multiple days of care, *if it is part of one episode of care*.

See sample claim below.

FIGURE 1: ED Outpatient Claim (Bill Type = 131)



iv. Observation Services

Observation is established to reimburse services that are provided when a member's current condition does not warrant an inpatient admission but does require an extended period of observation to evaluate and treat the member. Observation services should be used only for members who do not meet medical necessity for inpatient admission. The need for 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.

Billing of observation services PRIOR TO 7/1/2020:

- For services dates beginning January 1, 2017, all observation claims must be billed with Revenue Code 0762 and HCPCS codes G0379 and G0378. Hospitals must use two revenue lines for observation, with the first Rev Code 0762 billed with HCPCS code G0379 representing one (1) unit along with zero-dollar (\$0.00) charges AND a second Rev Code 0762 billed with HCPCS code G0378 representing the number of time-based units along with the corresponding charges.
- Effective January 1, 2017, for dates of service 4/1/2016 through 12/31/16, providers have the option to bill Evaluation and Management codes with G0378 or may bill with G0379 with G0378 (as above).
- For service dates billed through 12/31/16, Revenue Code 0762 may be billed with one of the following HCPCS codes: 99218, 99219, 99220, 99234, 99235, or 99236. Providers must also use the Evaluation and Management procedure codes with G0378.
- For observation services that span multiple days (i.e. cross midnight): this is considered a single episode of care and an APL must be present on at least one of the dates of service (e.g. Rev Code 0450 with HCPCS 99284). However, both the G0378 and G0379 HCPCS are required for each day of service, in addition to the APL code.

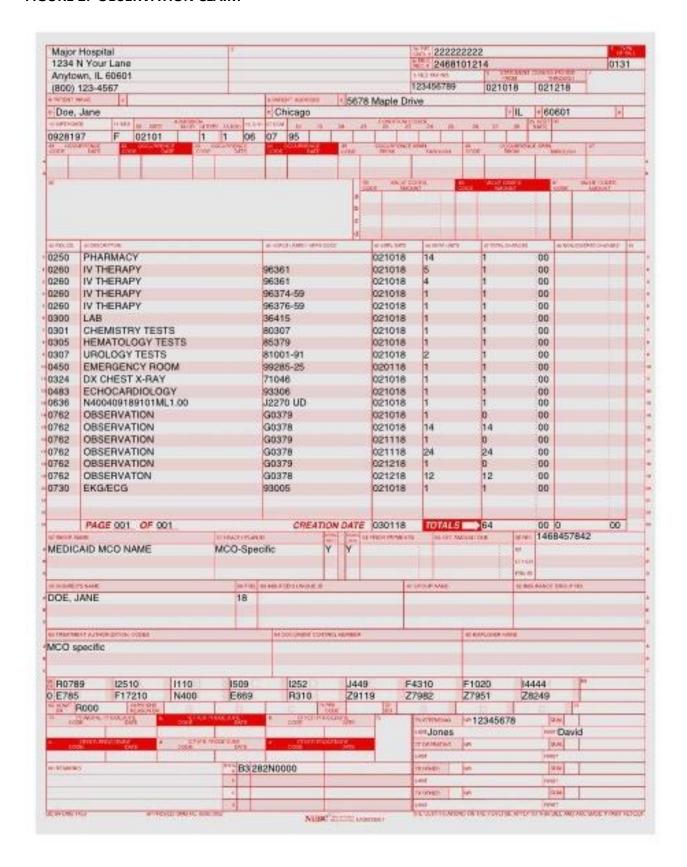
See claim sample on following page for dates of service prior to 7/1/2020.

Billing of observation services for dates of service ON OR AFTER 7/1/2020:

Billing of observation services will remain the same (same procedure and revenue codes), however the APL requirements are eliminated:

Observation Services						
Revenue Code	Procedure Code					
0762	G0379 G0378					
0762						
Both revenue lines above are requ	ired on an observation claim.					

FIGURE 2: OBSERVATION CLAIM



v. Psychiatric Services

MCOs reimburse hospitals for certain outpatient psychiatric services when provided in a hospital that is enrolled with HFS to provide inpatient psychiatric services (or was enrolled as such on or after 6/2/2002 but is no longer enrolled).

It is important that hospitals ensure the correct NPI and taxonomy codes are used.

The hospital must:

- use the General Acute Care hospital NPI and provider type 030;
- be registered for Categories of Service 027 or 028; and
- use the psychiatric unit taxonomy code (273R00000X).

Note: See taxonomy requirements in this manual for <u>Psychiatric Free-Standing Hospitals</u> if Provider Type 31.

The two categories of ambulatory psychiatric services that are eligible for reimbursement are:

- 1. Psychiatric Clinic Services, Type A (Category of Service 27)
 - These services are defined as an ambulatory service package consisting of diagnostic evaluation; individual, group or family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counselling.
 - b. Services are reimbursed at the EAPG all-inclusive rate, to include services provided by salaried personnel, drugs administered or provided for home use; and all equipment, drugs and supplies used for diagnostic and/or treatment purposes during the visit.
- 2. Psychiatric Clinic Service, Type B (Category of Service 28)
 - a. These services are defined as an active treatment program in which the individual 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. Members are limited to six (6) months in a Type B treatment program in any twelve (12) month period.
 - Services will be reimbursed at the EAPG all-inclusive rate and include services provided by salaried professional and ancillary personnel, and any expenses incurred for supplies and materials.

These services are paid under the EAPG system and require appropriate revenue and HCPCS codes.

Revenue codes 90x or 91x should be utilized. (see NUBC guidelines).

- Psychiatric Clinic Type A services must be billed with one of the following HCPCS Codes: 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90870, 90875, 90876, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, and 99215.
- Psychiatric Clinic Type B services must be billed with the following HCPCS Code: S9480. The
 S9480 code must be listed on EACH DAY of service no other APL code is required.
- <u>Psychiatric Clinic Type B intensive outpatient program (IOP)</u> claims must be coded with Revenue code 0913 (and HCPCS code S9480).

- <u>Psychiatric Clinic Type B Partial hospitalization program (PHP)</u> claims must be coded with Revenue Code 0912 (and HCPCS code S9480). A series bill can be submitted for PHP services, if patient is receiving PHP services on multiple days.
- HFS COS 027 and HFS COS 028 cannot be billed on the same claim.

vi. Series Billing for Claims PRIOR TO 7/1/2020:

Certain outpatient services provided on multiple days of service can be submitted on one UB-04 claim. A series claim must contain an appropriate series revenue code (see below) and series-billable procedure code from the APL. **ALL** services rendered to the patient on series-billable days are to be shown on the same claim. In addition, an APL must be present on each date of service for the claim to be accepted. A list of Series Billable APL codes can be found here. For series billing of Psychiatric Clinic B services, please see Psychiatric Billing above.

	Series-Billable Revenue Codes
Revenue Code	Revenue Description
0260	IV Therapy
0261	IV Therapy/Infusion Pump
0269	Other IV Therapy
0280	Oncology
0289	Other Oncology
0330	Radiology-Therapeutic
0331	Chemotherapy - Injected
0332	Chemotherapy - Oral
0333	Radiation Therapy
0335	Chemotherapy - IV
0339	Radiology - Therapeutic/Other
0340	Nuclear Medicine Or (NUC Med)
0341	Nuclear Medicine / Diagnostic
0342	Nuclear Medicine / Therapeutic
0343	Diagnostic Pharmaceuticals
0344	Therapeutic Radiopharmaceuticals
0349	Nuclear Medicine / Other
0410	Respiratory Services
0412	Inhalation Services
0413	Hyperbaric Oxygen Therapy
0419	Other Respiratory Services
0820	Hemodialysis - Outpatient or Home
0821	Hemodialysis - Composite or Other Rate
0829	Hemodialysis - Other Outpatient Dialysis
0830	Peritoneal Dialysis - Outpatient or Home
0831	Peritoneal Dialysis - Composite or Other Rate
0839	Other Outpatient Peritoneal Dialysis
0840	CAPD / Outpatient or Home
0841	CAPD / Composite or Other Rate
0849	Other Outpatient CAPD
0850	CCPD / Outpatient or Home
0851	CCPD / Composite or Other Rate
0859	Other Outpatient CCPD
0900	Psychiatric / Psychological Treatments
0901	Electroshock Treatment
0902	Milieu Therapy
0903	Play Therapy
0904	Activity Therapy
0911	Rehabilitation

	Series-Billable Revenue Codes
Revenue Code	Revenue Description
0912	Partial Hospitalization - Less Intensive
0913	Partial Hospitalization - Intensive
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0917	Bio Feedback
0918	Testing
0919	Other Psychiatric/Psychological Services

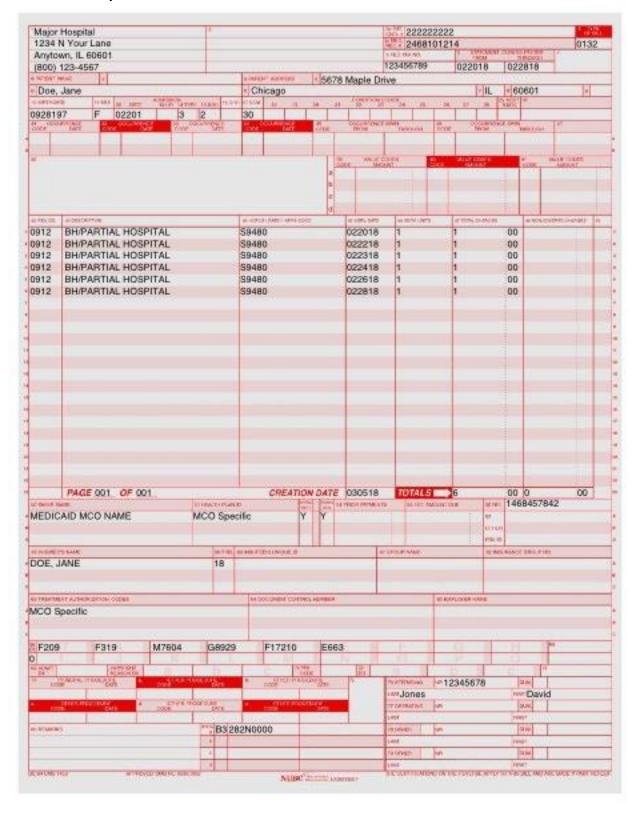
Series bills may be submitted for up to a maximum of thirty-one (31) days from the date of the first visit. If the series is longer than 31 days, the claim must be split. The date range for a series claim must include the beginning and ending service dates for the time period being billed. **DO NOT** automatically bill the first and last day of the month if services were not actually provided on those days.

Renal dialysis services can be billed as a series claim. However, claims for patients in the State Chronic Renal Disease Program **cannot cross** calendar months.

It is allowable, but not required, to split series claims around an inpatient stay. Outpatient claims that are not split must identify the inpatient days as non-covered, with a separate claim submitted for the inpatient stay.

See sample claim on the following page.

FIGURE 3: Sample Series Billed Claim:



Billing with Different Taxonomies for Multiple Categories of Service

For claims with dates of service on or after 7/1/2020, claims will no longer be required to contain specified series-billable procedure codes or revenue codes. Multiple days of service can be billed on one claim; however, providers must either bill around inpatient stays or show those days as a non-covered date span on the outpatient claim. The 'From' and "Through' dates of service must be the actual beginning and ending service dates for the outpatient services and cannot exceed 31 days.

Changes to Categories of Service During a Course of Treatment:

When billing for a patient with multiple outpatient dates of service with different Categories of Service (COS), (See Section II-C <u>Provider Types/COS/Taxonomy Codes</u>) the days will need to be split across claims, as only one Taxonomy Code can be billed on a claim.

<u>Example:</u> Hospital is enrolled in IMPACT for general outpatient (HFS COS 024), outpatient psychiatric clinic (HFS COS 027) as well as ESRD services (HFS COS 025).

The Patient receives the following services:

- Emergency Room visit on 07/05/2020
- Receives a scheduled outpatient CAT Scan on 07/10/2020
- Receives a scheduled outpatient psychiatric clinic service on 07/14/2020
- Second Emergency Room visit on 7/15/2020
- Receives dialysis while in the Emergency Room and 7/15/2020
- Receives psychiatric clinic services on 07/17/2020 and 07/19/2020.
- Dialysis in center or unit on 7/20/2020, 7/23/2020, and 7/31/2020

In this scenario, the hospital should bill each service date on a separate claim (total of 6 claims), using the appropriate Taxonomy Code for each service.

Alternatively, the hospital could submit (5) claims as follows:

Claim 1: Use General Acute Care Hospital Taxonomy Code.

Statement Date 07/05/2020 - 07/10/2020.

Claim is for the Emergency Room on 07/05/2020 and the CAT Scan on 07/10/2020. Provider is hospital with HFS COS 024 attested on the IMPACT provider file will be reimbursed EAPG for services in the ER and the CAT Scan.

Claim 2: Use Psychiatric Unit Taxonomy Code.

Statement Date 07/14/2020-07/14/2020

Claim is for the outpatient psychiatric clinic service on 07/14/2020.

Provider that is a hospital with HFS COS 027 attested on the IMAPCT provider file will be reimbursed EAPG for services in HFS COS 027.

Claim 3: Use General Acute Care Hospital Taxonomy Code.

Statement Date 07/15/2020-07/15/2020

Claim is for the Emergency Room visit on 07/15/2020 and dialysis services for revenue code 0820 on 07/15/2020.

Provider should bill the appropriate value code 80 of 1 as HFS Series billing rules apply for outpatient dialysis services.

Provider that is a hospital with HFS COS 024 and HFS COS 025 attested on the IMPACT provider file, will be reimbursed EAPG for all services including dialysis in a single episode of care when services are provided in an outpatient ER setting.

Claim 4: Use Psychiatric Unit Taxonomy Code.

Statement Date 07/17/2020-07/19/2020

Claim is for the psychiatric clinic services on 07/17/2020 and 07/19/2020.

Provider that is a hospital with HFS COS 027 attested on the IMAPCT provider file

will be reimbursed EAPG for services in HFS COS 027.

Claim 5: Use ESRD Taxonomy Code 261QE0700X.

Statement Date 07/20/2020-07/31/2020

Claim is for 3 dialysis services on 7/20/2020, 7/23/2020 and 7/31/2020 in the dialysis center or unit. Provider should bill the appropriate value code 80 of 3 as

series billing rules apply for outpatient dialysis services.

Provider that is a hospital with HFS COS 025 attested on the IMAPCT provider file

will be reimbursed per diem for services in HFS COS 025.

Hospitals should note that mixtures of a single episode of care in the ER billed with or without the combinations of HFS COS during that single episode of care allow for these base affiliations:

Outpatient Facility Claims

Services Rendered Outpatient	HFS Category of Service	Base Detail
Acute Care Only	024	Acute Care Medical EAPG base
Rehab Care Only	029	Rehab EAPG base given for COS 029. If COS 029 is not available for the facility, defaults to the Acute Care Medical EAPG base if the provider is registered for HFS COS 024.
Psych Care Only	027 OR 028	Psych EAPG base If provider is not registered on IMPACT for HFS COS 027 or HFS COS 028, not payable.
Dialysis Care Only	025	Per diem
ER Acute and Rehab services	024	Defaults to the Acute Care Medical EAPG base if the provider is registered for HFS COS 024.
ER Acute and Psych Care	024	Defaults to the Acute Care Medical EAPG base if the provider is registered for HFS COS 024.
ER Acute and Dialysis	024	Defaults to the Acute Care Medical EAPG base if the provider is registered for HFS COS 024.
ER Acute, Psych, Rehab Care	024	Defaults to the Acute Care Medical EAPG base if the provider is registered for HFS COS 024.
ER Acute, Psych, Rehab Care and Dialysis	Not expected scenario	Not expected scenario

Note: For inpatient stays where Dialysis was performed, refer to the inpatient section of this manual.

The provider does not need to bill separately for dialysis services in inpatient. Claim including the dialysis is reimbursable via the APR DRG pricing methodology.

vii. Pharmacy and Reporting of National Drug Codes

Federal law requires Medicaid programs collect rebates from drug manufacturers on claims for outpatient drugs, including claims billed by non-pharmacy providers. To collect rebates, claims must contain accurate NDCs and the quantity of the drug administered at the NDC level. Effective with dates of service on or after July 1, 2014, hospitals are required to identify the NDC in Field 43 of the UB-04 for **ALL** outpatient drugs billed.

Providers are required to detail revenue code line reporting when billing for more than one NDC per HCPCS code in conjunction with **ANY** revenue code. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code. *Each Revenue Code line must contain detailed reporting*.

MCO's validate NDCs using a pharmacy database such as First Databank or MediSpan. **Ensure NDCs used are validated against a similar pharmacy database and that the NDC is valid on the date of service to ensure a clean claim submission.**

The standard code set for NDCs is eleven (11) digits in a 5-4-2 configuration with no hyphens, spaces, or other characters.

IMPORTANT NOTE: Sometimes the NDC on the actual product label might not contain 11 digits. The labeler may have dropped leading zeroes in a segment. In this situation, the appropriate number of leading zeroes must be added at the beginning of each segment to ensure a 5-4-2 format. Where the zero is added will depend upon the configuration of the NDC.

For illustration purposes, the table below provides examples on incorrectly configured NDCs and the corresponding corrections:

Label Configuration	Add Leading Zero/Remove Hyphens
4- 4-2 (XXXX -XXXX-XX)	O XXXXXXXXX
5- 3 -2 (XXXXX- XXX -XX)	XXXXX 0XXX XX
5-4- 1 (XXXXX-XXXX- X)	XXXXXXXXX 0X

ALL NDC codes must include a prefix qualifier of N4, the 11-digit NDC code (without hyphens) and unit of measurement in field 43 (with corresponding revenue code). See example below:

-1									
	42	REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	1	0258	N400338004904ML1000	J7030	102918	10	20 00		
	2	0636	N400409113403ML10	J2270	102918	10	1 00		
	3	0636	N400378031593ML1	Q0162	102918	5	3 00		
	4								1 1

IMPORTANT NOTE: While general pharmacy services (e.g. Revenue Codes 025X) do not require NDC codes to be billed on the corresponding revenue service line, if a facility provider does use a HCPCS code, the code will be validated against HFS' Practitioner Fee Schedule to determine if it requires an NDC code, regardless of the revenue code used on the claim. If you do use a HCPCS code with Pharmacy Revenue Codes 0250-0259, be sure to verify the HFS Practitioner Fee Schedule to see if an NDC code must be added. If the fee schedule for the HCPCS has the 'NDC Ind' field = 'Y', then the revenue code/HCPCS combination must contain a valid NDC. The Fee Schedule can be found here.

Example:

							Pr	actitione	r Fee Sch	eaule	Eff	ective 10/01	72018 U	pdated 10/22/20	ארנ				
his fee sche	dule ap	plies to	charges sub	mitte	d by th	e folic	wing	providers:	Advanced	Practic	e Nurse	s, Dentists pro	viding medi	cal services, Fee-Fo	or-Service	Hospitals,	Imaging Ce	enters,	
ndependent	Diagno	stic Te	sting Facilities	s (IDT	ΓFs), Inc	lepen	dent l	Laboratori	es, Local F	lealth [Departm	ents, Optomet	rists providin	g medical services,	Physician	s, and Po	rtable X-ray	/ Companies.	
ncounter Ra	ate Clini	ics (ER	cs), Federally	Qua	lified He	alth (Cente	rs (FQHCs), and Rura	al Healt	h Cente	rs (RHCs) sho	uld utilize thi	s fee schedule for	a listing of	covered s	ervices billa	able as detail coo	des.
lease note t	he app	earanc	e of a code o	n thi	s fee so	hedu	le doe	s not gua	rantee pay	ment.	Services	for which me	dical necess	ity is not clearly est	ablished a	re not cov	ered by the	Department's N	Medical
rograms. S	ee Han	dbook	or Providers	of M	edical S	ervice	s, Top	oic 104 an	d Practition	ners Ha	ındbook	, Section 204	for additiona	ıl exclusions. Upda	ites are ba	sed on pe	eriodic mod	ifications to the I	HCPCS/CPT code
CPT codes a	nd desc	criptions	only are cop	yrigh	nt 2018	by the	Ame	rican Med	ical Associ	ation.	All Right	s Reserved. A	Applicable F	ARS/DFARS apply.	National	Correct Co	oding Institu	ite (NCCI) edits a	apply.
2.7% rate re	duction	s show	n in a separa	te co	lumn de	not:	apply	to: Physic	ians, Denti	sts, Ad	vanced	Practice Nurse	s, FQHCs, F	RHCs, ERCs, or Loc	al Health	Departme	nts.		
				_												Add-On			educed
				_		_				_						7100 011		by 2	2.7%
Procedure Code	Note	Prog Cov	Eff Date	HP	NDC Ind	Surg Ind	ΑV	M1 (26)	M2 (TC)	Asst Surg	Co- Surg	Unit price	Max Qty	State Max	Surg	Child	Adult	Unit price	State Max
J3473	Т	04	10/01/18	N	Υ	N						0.358	300	107.40				0.35	104.50
J3475	T	04	10/01/18	N	Υ	N					·	0.766	20	15.32				0.75	14.91
J3480	Т	04	10/01/18	N	Y	N						0.15	20	3.00				0.15	2.92
J3485	T	04	10/01/18	N	Υ	N					·	1.513	20	30.26				1.47	29.44
J3489	Т	04	10/01/18	N	Y	N						12.448	5	62.24				12.11	60.56
J3490	T, U*	04		Y	Υ	N													
J3530	Т	04		Y		N													
J3590	T	04		Y	Y	N													
J7121	Т	04	10/01/18	N	Y	N						1.95	3	5.85				1.90	5.69
J7131	T	04	10/01/18	N	Υ	N						.0044	500	2.24				0.00	2.18
J7175	T	04	10/01/18	N	Υ	N						6.00	9999	59,994.00				5.84	58,374.16
J7178	Т	04	10/01/18	N	Y	N						1.10	9100	10,010.00				1.07	9,739.73
J7179	Т	04	10/01/18	N	Y	N						1.45	9999	14,498.55				1.41	14,107.09
J7180	T	04	10/01/18	N	Υ	N						8.228	5000	41,140.00				8.01	40,029.22
J7181	T	04	10/01/18	N	Υ	N						10.24	4500	46,080.00				9.96	44,835.84
7182	T	04	10/01/18	N	Υ	N						1.34	6250	8,375.00				1.30	8,148.88
J7183	T	04	10/01/18	N	Υ	N						1.009	7500	7,567.50				0.98	7,363.18
J7185	T	04	10/01/18	N	Υ	N						1.222	6250	7,637.50				1.19	7,431.29
J7186	T	04	10/01/18	N	Υ	N						0.992	6250	6,200.00				0.97	6,032.60
J7187	T	04	10/01/18	N	Y	N						1.123	9999	11,228.88				1.09	10.925.70

Reporting Multiple NDCs

It may sometimes be necessary for providers to bill multiple NDCs for a single HCPCS code. This may happen when two different strengths of the same drug are needed to administer the appropriate dose. This will also be necessary when multiple vials of the same drug are used to administer the appropriate doses, and the vials are manufactured by different manufacturers. In these cases, modifiers 76 or 51 are to be included as appropriate. When a provider uses more than one NDC for a drug, the provider must include all NDCs on the claim. See examples below:

Example 1: Billing three (3) 250mg vials of ceftriaxone from two different manufacturers (the first line represents the drug manufactured by Sandoz, the second from Hospira):



Example 2: Billing 125mcg of Aranesp (darbepoetin alfa) using two different vials/strengths of the drug: one (1) 25mcg syringe and one (1) 100mcg syringe.

			d					
	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0252	N455513005704mcg1	J0881	10122018	25			
2	0252	N455513002504mcg1	J0881 76	10122018	100			
3								

Discarded Drugs

Use the modifier **JW** in FL 44 to identify the drug amount remaining from a single use vial that is discarded or not used.

340-B Purchased Drugs

Effective with dates of service on and after July 14, 2014, hospitals must identify **ALL** 340-B purchased drugs by reporting modifier "**UD**" in FL 44 of the UB-04 claim. Modifier "UD" must be the FIRST modifier listed after the HCPCS drug code.

D. Non-APL Billing - Applies to Claims with Dates of Services prior to 7/1/2020 Only

If the outpatient services provided do not fall into one of the following categories:

- A valid Ambulatory Procedure Listing (APL) procedure code, which is valid on the date of service; OR
- One Emergency Department (ED) revenue code with an associated HCPCS code OR
- Observation (OBV) revenue codes with any associated HCPCS codes.

Then the services must be billed on a CMS1500 (837P) with the registered professional service NPI.

Hospitals can bill directly on a fee-for-service basis for the following Categories of Service (COS):

- 001 Provider Services
- 011 Physical Therapy Services
- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services
- 014 Audiology Services
- 017 Anesthesia Services
- 030 Healthy Kids Services
- 040 Pharmacy Services (Legend and OTC)
- 041 Medical Equipment/Prosthetic Devices
- 048 Medical Supplies

These COS' are limited to the following procedures:

- Administration of chemotherapy for the treatment of cancer
- Administration and supply of the following medications:
 - Chemotherapy agents for the treatment of cancer
 - Non-chemotherapy drugs administered for the side effects that may occur during the administration of a chemotherapy agent. Claims must be submitted with the cancer-related diagnosis
 - Baclofen
 - Lupron

- RhoGAM
- Tysabri
- Reference (outside) laboratory services (indicate with Modifier 90)
- Laboratory services performed on-site, technical component only (indicate with TC modifier), ordered by a practitioner. The claim for the professional services of the pathologist, whether the pathologist is salaried by the hospital or not, must be submitted under the name and NPI of the pathologist.
- Radiology services that are not included on the APL listing, may be billed for the technical component only as ordered by a practitioner.
- Durable medical equipment and supplies
- Physical, Occupational and Speech therapy
- Audiology services
- Telehealth originating site only
- OB triage billed as 99211 with modifier TH when there is no billable APL procedure
- Technical component CPT code for an ECG procedure (tracing only, without interpretation and report)
 - effective with dates of service on and after July 1, 2016. (The global CPT code for an ECG procedure
 - routine ECG with 12 leads; interpretation and report) should not be billed by hospitals in the hospital outpatient setting.

Claims must be billed under the hospital's name and Medicaid registered professional NPI.

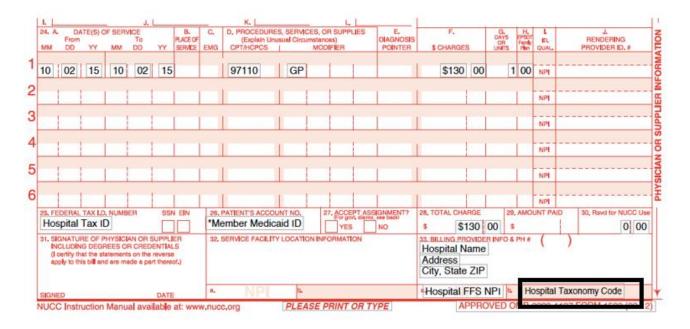
Hospitals may not bill separately for lab, radiology, or OB triage when an APL is present on the same day.

Payment for these services will be based on the same fee schedule and billable codes that apply to these services when they are provided in the non-hospital setting, except for physical therapy and occupational therapy which will pay at the APL rate.

Hospitals must include the following modifier/CPT combination to receive the APL rate:

- GP Required when billing Physical Therapy services procedure code 97110 or evaluation code 97001
- GO Required when billing Occupational Therapy services procedure code 97110

Claims submitted without the appropriate modifier will be denied. In addition, billing for appropriate drugs must include the correct eleven (11) digit NDC code following the HCPCS code. As an example, a hospital billing a CPT code 97100 with modifier GP for physical therapy should use the hospital fee-for-service NPI associated with the registered Medicaid ID that correlates to COS 011.



E. Outpatient Dialysis Services (ESRD)

The following guidance applies to providers who are registered to provide services for End-Stage Kidney Disease, also called End-Stage Renal Disease (ESRD), and dialysis treatment.

Ambulatory End Stage Renal Disease Treatment (ESRD) services are defined by HFS 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. Dialysis providers can be either specialty free-standing chronic dialysis centers certified by Medicare, an outpatient renal dialysis department of the hospital, or a satellite unit of the hospital.

HFS does not have an independent or free-standing chronic dialysis center/ESRD defined provider type within its processes today. Free-standing chronic dialysis centers get assigned as provider type 30- General Acute Hospital with the 025 Category of Service (COS) - Outpatient Services (ESRD) via IMPACT (example: DaVita). If the provider type 30 in IMPACT includes registrations for COS 024-Outpatient Services as well as COS 025 – Outpatient Services (ESRD), then the provider is a hospital and can provide renal services in a dedicated outpatient department or a satellite unit of the hospital.

i. Taxonomy and Category of Services

Providers who are independent or free-standing chronic dialysis center services or a dedicated dialysis unit only billing renal services:

HFS Category of	HFS Category of Service	Taxonomy
Service Code	Description	
025	Outpatient Services (ESRD)	261QE0700X (ESRD Treatment)

For providers who also are attested to provider COS 24- Outpatient Services as well as COS 25- Outpatient Services (ESRD), then the provider can use the general acute care taxonomy if there are other services being billed on the claim. Please refer to the <u>Billing with Different Taxonomies for Multiple HFS Categories of Service</u> section of the Outpatient Hospital Section.

ii. Covered Services:

Outpatient ESRD treatment provided by hospitals in a dedicated renal unit, satellite unit of the hospital, and freestanding dialysis facilities is reimbursed based on a per diem (per day) basis plus a \$60.00 add on per treatment day. This is an all-inclusive rate, 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.

Certain injectable drugs billed on outpatient dialysis claims are reimbursed as an add-on to the per diem rate. The covered injectable drug can be found at following location Renal Dialysis Injectable Drugs Listing and reimbursed based on the IL Practitioner Fee Schedule.

iii. Billing Requirements

- All Dialysis claims must be billed in an electronic format using the HIPAA 5010 837I.
- If CPT Q4081 for Erythropoietin (Epogen) billed on claim then,
- must be billed with value code 68 (represents number of units billed)
- must be accompanied with revenue codes 634 or 635
- 261QE0700X must be billed on the claim indicating Renal Dialysis.
- Dialysis revenue codes and injectable drug revenue codes 0634, 0635, and 0636 require a separate service line for each date of service.
- Modifier "UD" is required to denote all 340B-purchased drugs. Modifier "UD" must be the first modifier listed after the HCPCS procedure code.
- Dialysis is still considered a series billable service and as a result Value Code 80 with the number of dialysis treatments (Covered Days) must be part of the claim.
- When billing outpatient ESRD, revenue codes 0821, 0831 or, 0881 must not be billed with revenue codes 0841 or 0851 on the same claim. Series claims for renal dialysis must be split if the patient received more than one type of dialysis during the treatment span.
- When billing for home daily dialysis revenue codes 0841 or 0851, the sum of Value code 80 Covered Days plus Noncovered Days must equal the Statement Covers Period.
- Claims should not be held by providers. Always submit the claim within the appropriate cycle for processing.
- Revenue codes to be used for per diem billings, HFS COS 025, provided on a dedicated unit:

Revenue Code	Description
0821	Hemodialysis -Outpatient or Home Composite or Other Rate
0831	Peritoneal Dialysis – Outpatient or Home Composite or Other Rate
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD)- Outpatient or Home- Composite or Other Rate
0851	Continuous Cycling Peritoneal Dialysis (CCPD)-Composite or Other Rate
0881	Miscellaneous dialysis-ultrafiltration

The following revenue codes are also eligible to be billed with the per diem codes, HFS COS 025 on an outpatient basis:

Revenue Code	Description
0820	General Hemodialysis Outpatient or Home
0829	Other Hemodialysis Outpatient or Home
0830	General Peritoneal Dialysis Outpatient or Home
0839	Other Peritoneal Dialysis Outpatient or Home
0840	General Continuous Ambulatory Peritoneal Dialysis (CAPD)-Outpatient or Home
0849	Other Continuous Ambulatory Peritoneal Dialysis (CAPD)-Outpatient or Home
0850	General Continuous Cycling Peritoneal Dialysis (CCPD)-Outpatient or Home
0859	Other Continuous Cycling Peritoneal Dialysis (CCPD)- Outpatient or Home
0880	General Miscellaneous Dialysis Code- Outpatient Home
0889	Other Miscellaneous Dialysis Code – Outpatient or Home

Non-Covered Dialysis Revenue Codes

Providers should note HFS has certain Non-Covered Revenue Codes related to dialysis treatment. The specific dialysis codes are noted below from the list of non-covered revenue codes that is located at the end of the outpatient section. You can also view by clicking here for the complete list.

Non-Covered Revenue Code	Description
0822	Hemodialysis / Home Supplies
0823	Hemodialysis / Home Equipment
0824	Hemodialysis / Home Equipment
0825	Hemodialysis / Support Services
0832	Peritoneal Dialysis / Home Supplies
0833	Peritoneal Dialysis / Home Equipment
0834	Peritoneal Dialysis / Maintenance 100%
0835	Peritoneal Dialysis / Support Services
0842	CAPD / Home Supplies
0843	CAPD / Home Supplies
0844	CAPD / Maintenance 100%
0845	CAPD/Support Services
0852	CCPD/Home Supplies
0853	CCPD/Home Equipment
0854	CCPD/Maintenance 100%
0855	CCPD/Support Services
0882	Home Dialysis Aide Visit

The following bill types are allowed for outpatient dialysis services:

Type of Bill
131, 132, 133, 134, 135
721, 722, 723, 724, 725
731, 732, 733, 734, 735
851, 852, 853, 854, 855

Hospitals billing a single outpatient episode of care with ER service:

The following renal revenue codes can be billed by hospitals in the same episode of care when part of an ER episode of care:

Revenue Code	Description
0810	General Outpatient Acquisition of Body Components
0820	General Hemodialysis- Outpatient or Home
0829	Other Hemodialysis – Outpatient or Home
0860	General Magnetencephalography
0861	MEG
0889	Other Miscellaneous Dialysis

Note: CPT Q4081 for Erythropoietin (Epogen) with revenue code 634 or 635 is not allowed to be billed when part of an ER episode of care.

Series Billing Dialysis Revenue Codes

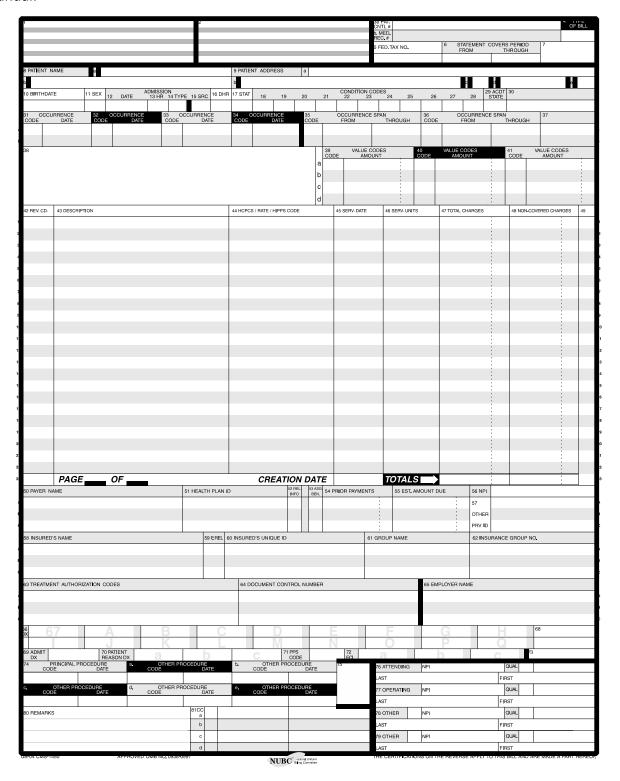
The following revenue codes are dialysis that can be billed as series billing. The specific dialysis codes are noted below from the list of series billable revenue codes that is located at the end of the outpatient section. These dialysis codes are still series billable after 7/1/2020. You can also view by clicking here for the complete list.

Revenue Code	Description	
0820	Hemodialysis - Outpatient or Home	
0821	Hemodialysis - Composite or Other Rate	
0829	Hemodialysis - Other Outpatient Dialysis	
0830	Peritoneal Dialysis - Outpatient or Home	
0831	Peritoneal Dialysis - Composite or Other Rate	
0839	Other Outpatient Peritoneal Dialysis	
0840	CAPD / Outpatient or Home	
0841	CAPD/Composite or Other Rate	
0849	Other Outpatient CAPD	
0850	CCPD / Outpatient or Home	
0851	CCPD / Composite or Other Rate	
0859	Other Outpatient CCPD	

F. Sample Claims Forms

i. UB-04

MCOs follow the UB-04 specification manual as publish by NUBC except for exceptions noted in this manual.



ii. Sample CMS 1500 form

MCOs follow the CMS 1500 Reference Instruction Manual published by the NUCC committee, except for exceptions as noted in this manual.

ALTH INSURANCE CLAIM FORM				
OVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	?			
PICA				PICA
MEDICARE MEDICAID TRICARE CHAMP Medicare#) (Medicaid#) (ID#/DoD#) (Member	— HEALTH PLAN — BLK LUNG — I	1a. INSURED'S I.D. NUMBER		(For Program in Item 1)
TIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4, INSURED'S NAME (Last Nan	ne, First Name,	Middle Initial)
TIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No.,	Street)	
STATE	Self Spouse Child Other 8. RESERVED FOR NUCC USE	CITY		STATE
ODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHON	E (Include Area Code)
()			()
HER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROU	P OR FECA NU	JMBER
HER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH	H M	SEX F
SERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designate	ed by NUCC)	
SERVED FOR NUCC USE	c. OTHER ACCIDENT?	c, INSURANCE PLAN NAME OF	R PROGRAM N	NAME
SURANCE PLAN NAME OR PROGRAM NAME	10d, CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALT		
READ BACK OF FORM BEFORE COMPLETIN	IG & SIGNING THIS FORM.	YES NO 13. INSURED'S OR AUTHORIZ	ED PERSON'S	
A HENT'S OR AUTHORIZED PERSON'S SIGNATURE Tauthorize the process this claim. I also request payment of government benefits either slow.	a release of any medical or other information necessary or to myself or to the party who accepts assignment	payment of medical benefits services described below.	to the undersig	ned physician or supplier for
GNED	DATE	SIGNED		
	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO THE TOTAL TO THE TOTAL TO THE TOTAL TO	TO WORK IN C TO	URRENT OCCUPATION MM DD YY
AME OF REFERRING PROVIDER OR OTHER SOURCE	ra. b. NPI	18. HOSPITALIZATION DATES	RELATED TO	CURRENT SERVICES MM DD YY
DDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$ C	HARGES
AGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to see	vice line below (24E) ICD Ind.	YES NO 22. RESUBMISSION CODE	ORIGINAL R	FF. NO.
В. С.		23. PRIOR AUTHORIZATION N	UMBER	
F G. K.	H. L. L.			
	EDURES, SERVICES, OR SUPPLIES lain Unusual Circumstances) PCS MODIFIER POINTER	F. G. DAYS OR UNITS	H. I. EPSDT Family ID. Plan QUAL.	J. RENDERING PROVIDER ID. #
			NPI	
			NPI	
EDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28, TOTAL CHARGE 29	a AMOUNT PA	ID 30. Rsvd for NUCC L
IGNATURE OF PHYSICIAN OR SUPPLIER ICLUDIND DEGREES OR CREDENTIALS certify that the statements on the reverse ply to this bill and are made a part thereof.)	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO 8	·)
a	DI b.	a. NDI b.		
ED DATE "	PLEASE PRINT OR TYPE	APPROVED (

G. Outpatient Hospital Billing Scenarios

Assumptions:

The following are common scenarios that often present billing issues for hospitals. This guidance is intended to clarify correct claim submission requirements for successful adjudication and payment by the Health Choice Illinois Medicaid Managed Care Organizations (MCOs). For all scenarios, it is assumed:

- Member is active, and hospital is in-network on the day(s) of service;
- Any authorizations for service(s) are completed and included on claim, as applicable;
- Hospital NPI is registered in IMPACT for Category of Service
- Appropriate taxonomy code is present based on service type (click <u>here</u> for a listing of taxonomy codes);
- Physician is in-network, credentialed and active;
- Patient is assigned an accurate plan number;
- Claim form is accurate for the provider setting;
- Patient demographics (e.g., sex, age, etc.) are accurate for the services billed (do not conflict with any additional coding edits specific to these elements);
- "From," "Through," and "Admission" (if applicable) dates are accurate; and
- Bill type used is accurate for services rendered.

Scenario 1: Ambulatory Procedures Listing (APL) Policy for a Single Episode of Care

Claim assumption: Prior to 7/1/2020

Patient presents for a scheduled outpatient procedure (e.g., insertion of implantable cardiac defibrillator system). Patient needs extended recovery services that extend to a second date of service but remains in outpatient status (OP in a bed). No observation placement occurs (no medical necessity is assumed), so no charges for observation are present on the claim (Bill Type = 131). Ancillary tests and administration of IV drugs are given on the day following the procedure only; no other procedures or APL codes are present on the claim for the second date of service. Patient's stay spans over two dates of service as an outpatient.

This scenario represents a *single episode of care* that spans two days. It would be billed as a non-series claim.

Only one APL code is required across multiple days if the outpatient services are all part of a single episode of care. The services would be billed as a non-series claim. (An APL code is required for each covered service date of a series bill.)

Hospitals should bill MCOs as they would bill HFS for this scenario as the edit logic is equivalent.

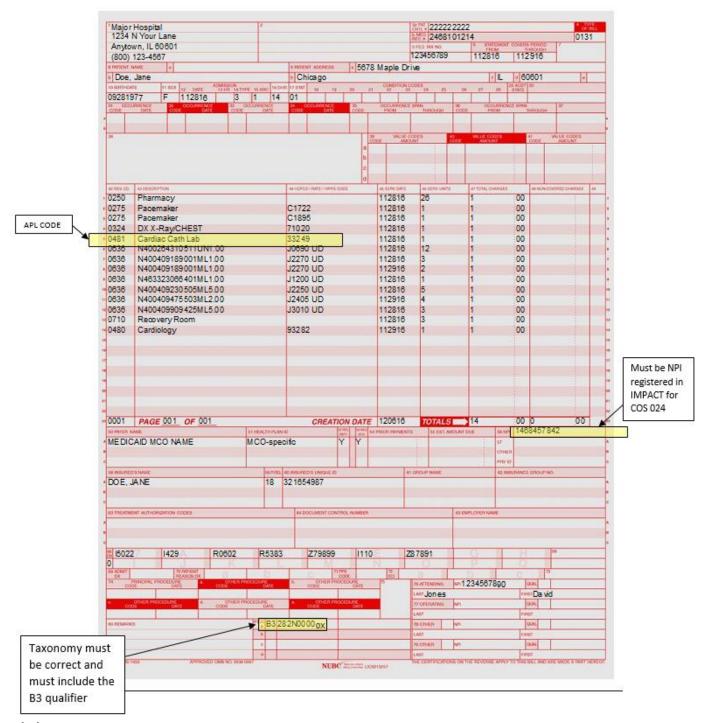
IMPORTANT NOTE: Effective December 7, 2017 - MCOs have updated their system edits to accept and adjudicate claims hospital outpatient claims for a single episode of care that span two or more days when there is no APL code present on the second and/or subsequent days.

Billing Requirements for Scenario 1 (Non-Series Claims):

- The outpatient claim must have at least 1 APL code on the claim in an 837I/UB-04 format
- Ensure the bill type (for the scenario above) is 0131 (FL 4)
- All fields should be completed based on the service(s) being performed, including but not limited to:
 - Facility Name FL 1
 - Patient Name FL 8b
 - Date of Birth FL 10
 - Sex FL 11
 - Statement Date from and through (required) FL 6
 Date of Service is prior to 7/1/2020
 - Relevant condition codes (when applicable) FL 18-29
 - Relevant occurrence codes (when applicable) FL 31-36
 - Value codes and amounts (when applicable) 39-41
 - Revenue Code (required) FL 42
 - HCPCS code (required) FL 44
 - Service dates, units, and charges (required) FL 45-47
- NPI numbers are critical to the submission and payment process
 - Ensure the Hospital NPI related to outpatient services is located in box 56
 - Note: This should be the NPI registered with HFS in IMPACT for the outpatient category of service (024)
 - Include the NPI of the Attending Physician in FL 76
 - o Include the NPI of the Operating Physician (when applicable) in FL 77
 - FL 66 should include the primary and any secondary diagnosis codes

See sample claim on the following page.

Claim Example: Non-Series Claim (OP visit spanning two days/single episode of care) Claim prior to



7/1/2020

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Scenario 1A: Outpatient Claim Policy for a Single Episode of Care

Claim assumption: Date of service on or after 7/1/2020

Patient presents for a scheduled outpatient procedure (e.g., insertion of implantable cardiac defibrillator system). Patient needs extended recovery services that extend to a second date of service but remains in outpatient status (OP in a bed). No observation placement occurs (no medical necessity is assumed), so no charges for observation are present on the claim (Bill Type = 131). Ancillary tests and administration of IV drugs are given on the day following the procedure only; no other procedures are present on the claim for the second date of service. Patient's stay spans over two dates of service as an outpatient.

This scenario represents a single episode of care that spans two days.

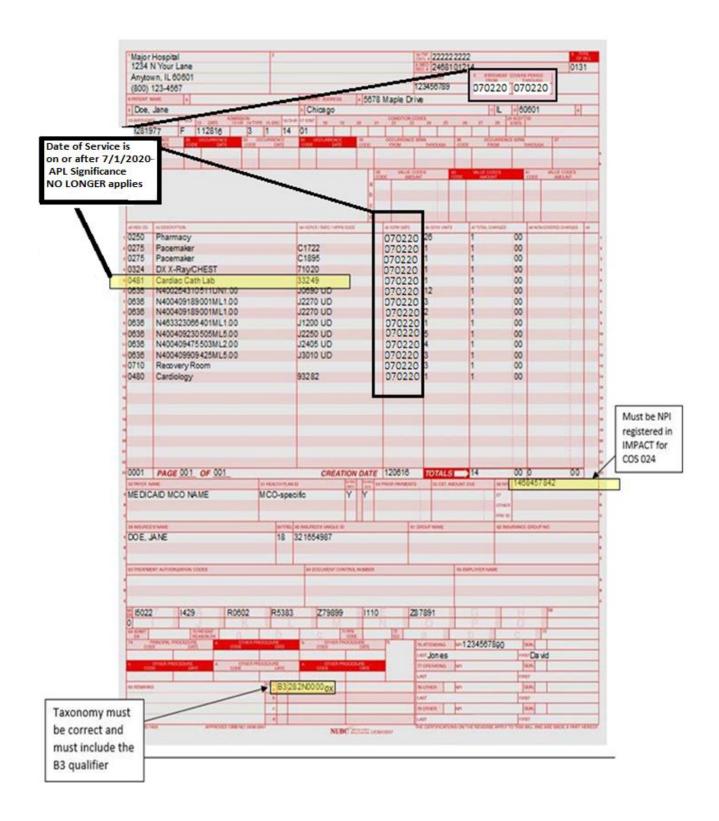
The outpatient services are all part of a single episode of care.

Hospitals should bill MCOs as they would bill HFS for this scenario as the edit logic is equivalent.

Billing Requirements for Scenario 1A:

- Ensure the bill type (for the scenario above) is 0131 (FL 4)
- All fields should be completed based on the service(s) being performed, including but not limited to:
 - Facility Name FL 1
 - Patient Name FL 8b
 - Date of Birth FL 10
 - Sex FL 11
 - Statement Date from and through (required) FL 6 Must be on or after Date of Service
 7/1/2020
 - Relevant condition codes (when applicable) FL 18-29
 - Relevant occurrence codes (when applicable) FL 31-36
 - Value codes and amounts (when applicable) 39-41
 - o Revenue Code (required) FL 42
 - o HCPCS code (required) FL 44
 - Service dates, units, and charges (required) FL 45-47
- NPI numbers are critical to the submission and payment process
 - o Ensure the Hospital NPI related to outpatient services is located in box 56
 - Note: This should be the NPI registered with HFS in IMPACT for the outpatient category of service (024)
 - Include the NPI of the Attending Physician in FL 76
 - o Include the NPI of the Operating Physician (when applicable) in FL 77
 - FL 66 should include the primary and any secondary diagnosis codes See sample claim on the following page.

See sample claim on the following page.



Scenario 2A: ED with Inpatient Admission on the Same Date of Service

Emergency Room services billed on the same date as an inpatient admission are allowed by all MCOs. Services provided prior to the admission that were performed in the emergency and/or other outpatient departments should be included on the Inpatient claim (TOB 111). Remember that all outpatient claims must contain at least one APL procedure code, or an emergency department or observation revenue code listed below.

This scenario will require the submission of two (2) claims. The emergency room service in this instance must be **billed separately** on an outpatient claim (Sample Claim 1 below) while *all ancillary charges* accumulated within the emergency and other departments during this time are submitted on the inpatient claim (Sample Claim 2 below).

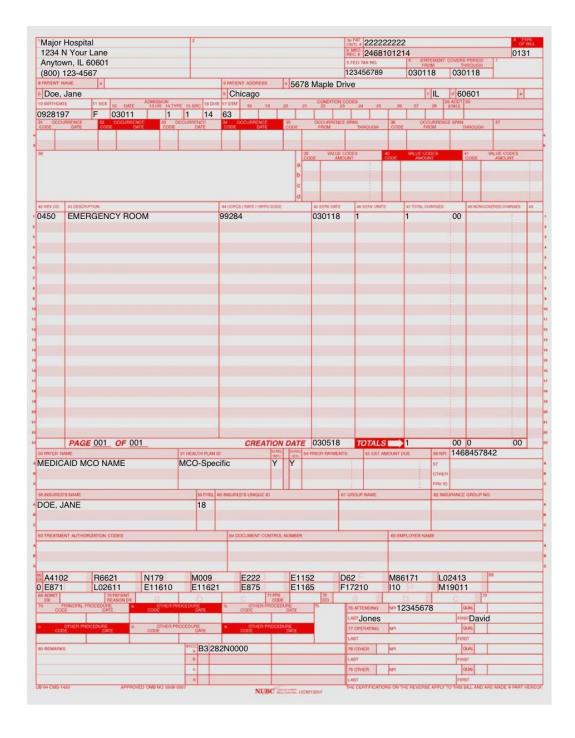
For appropriate EAPG pricing and allowance for outpatient emergency services, the claim must include an Emergency Revenue Code(s) of 450, 451 or 456 with the related HCPCS Code 99281 - 99291 & G0380 – G0384. The following Emergency Room Services grid and claim example both identify the payable Revenue and HCPCS code combinations.

Emergency Room Services

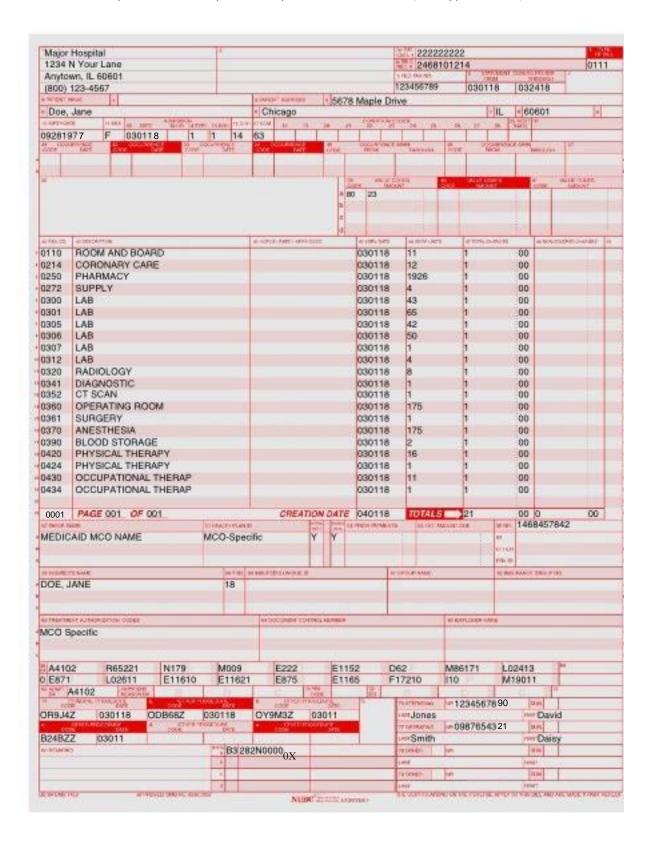
Revenue Code	HCPCS Code
0450	99284, 99285, 99291, G0383, G0384
0451	99281, G0380
0456	99282, 99283, G0381, G0382

See claim examples for both the Emergency Room Outpatient claim and the accompanying Inpatient claim on the following pages.

Claim Example 1: Emergency Room Services Only – (Bill Type = 0131)



Claim Example 2: All Inpatient services (e.g., room/board, procedures, drugs, and ancillary charges), and all other outpatient ancillary services prior to admission - (Bill Type = 0111)



Scenario 2B: ED/OBV visit with inpatient admission on subsequent day of service

This scenario, similar to Scenario 2A, will require the submission of two (2) claims. Claim 1 represents the ED visit and OBV services, including ancillary services provided, and Claim 2 represents the inpatient admission and any ancillary services provided during the inpatient stay.

PLEASE NOTE: Aetna Better Health has a different billing process for this scenario. Please see further guidance at the end of Scenario 2B claim examples on page 70.

Claim 1:

This will be a TOB 0131 and will include the ED visit, (See Scenario 2A), all ancillary services, and OBV services.

The following is specific guidance on billing observation services:

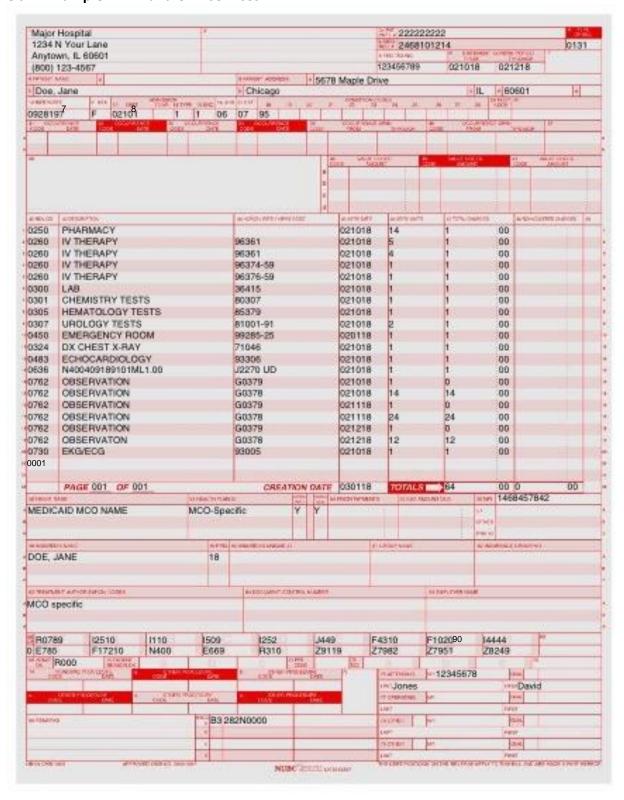
- For services dates beginning January 1, 2017, all observation claims must be billed with Revenue Code 0762 and HCPCS codes G0379 and G0378. Hospitals must use two revenue lines for observation, with the first Rev Code 0762 billed with HCPCS code G0379 representing one (1) unit along with zero-dollar (\$0.00) charges AND a second Rev Code 0762 billed with HCPCS code G0378 representing the number of time-based units along with the corresponding charges.
- Effective January 1, 2017, for dates of service 4/1/2106 through 12/31/16, providers have the option to bill Evaluation and Management codes with G0378 or may bill with G0379 with G0378 (as above).
- For service dates billed through 12/31/16, Revenue Code 0762 may be billed with one of the following HCPCS codes: 99218, 99219, 99220, 99234, 99235, or 99236. Providers must also use the Evaluation and Management procedure codes with G0378.

Claim 2:

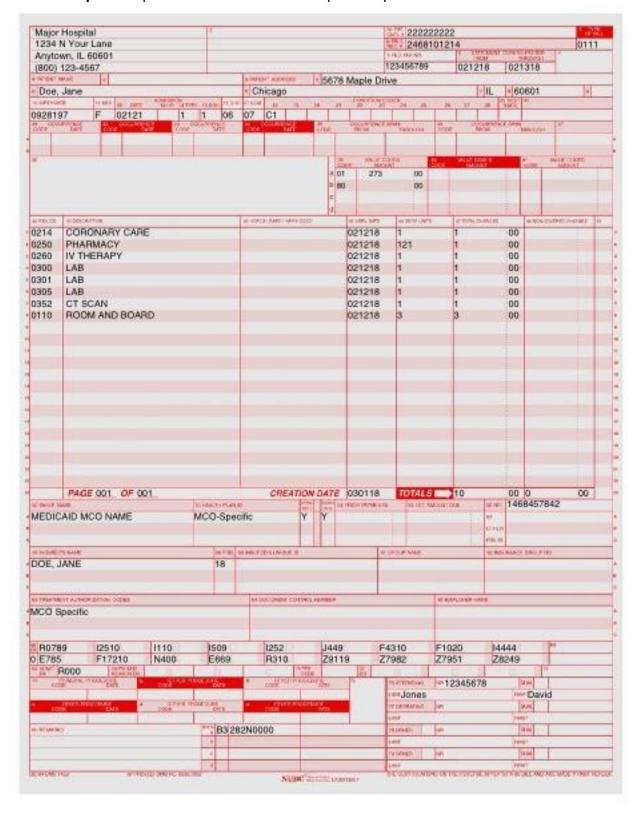
This claim will be TOB 0111 and will include charges for the inpatient room and board along with all other inpatient ancillary services.

Please see claim samples on the following pages.

Claim Example 1: ED and OBV services



Claim Example 2: Inpatient Admission on Subsequent Day of Service



Scenario 3: National Drug Code Reporting

In the scenario, the patient presents to the Emergency Department for IV therapy and ancillary testing. Patient is discharged from the ED as an outpatient. Detailed drugs will be listed on the claim with respective NDC numbers. MCOs validate NDCs against the MediSpan database. <u>Please ensure that</u>

<u>NDCs used are validated against MediSpan to ensure a clean claim submission.</u> This will be a Bill Type 0131.

Effective with dates of service on or after July 1, 2014, hospitals are required to identify the NDC in FL 43 of the UB-04 for all outpatient drugs billed. The standard code set for NDCs is eleven (11) digits in a 5-4-2 configuration.

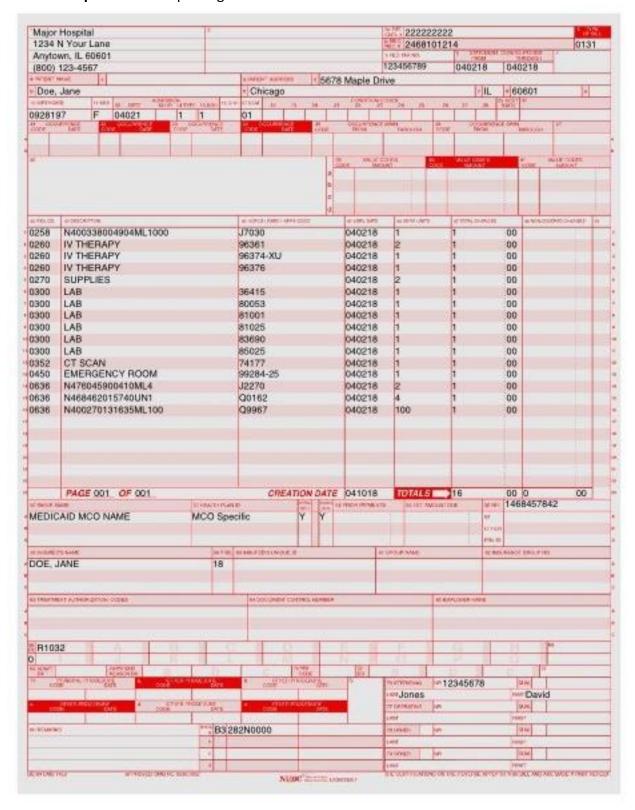
For example, 12345-1234-12 is a correctly configured NDC.

PLEASE NOTE: Sometimes the NDC on the actual product label might not contain 11 digits. The labeler may have dropped leading zeroes in a segment. In this situation, the appropriate number of leading zeroes must be added at the beginning of each segment to ensure a 5-4-2 format. Where the zero is added will depend upon the configuration of the NDC. For illustration purposes, the table below provides examples on incorrectly configured NDCs and the corresponding corrections:

NDC on Label	Configuration on Label	NDC in Required 5-4-2 Format
05678-123-01	5-3-2	05678-0123-01
5678-0123-01	4-4-2	05678-0123-01
05678-0123-1	5-4-1	05678-0123-01

ALL NDC codes must include a prefix qualifier of N4, the 11-digit NDC code (without hyphens) and unit of measurement in FL 43 (with corresponding revenue code). See UB-04 claim example on the following page.

Claim Example 1: NDC Reporting



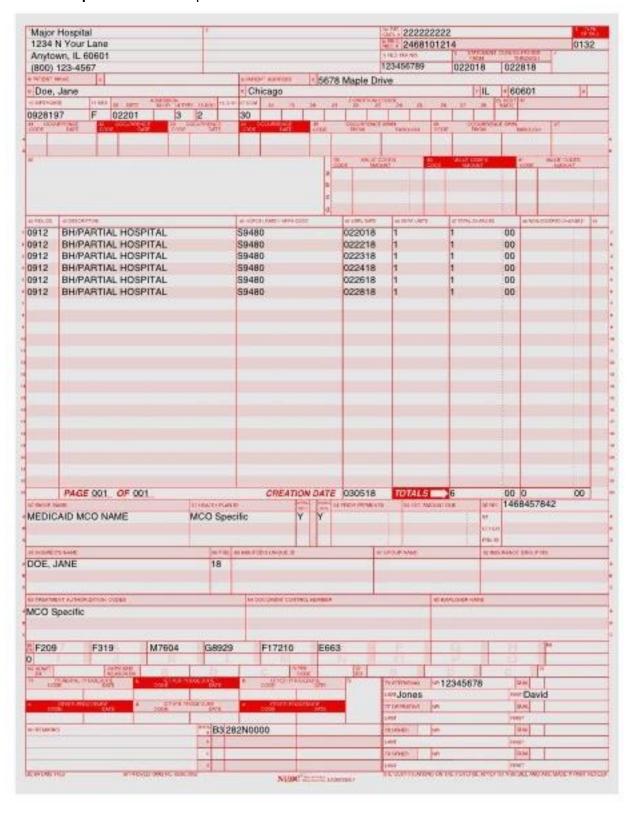
If the service being provided does not have an APL code (claims with dates of services prior to 7/1/2020), the claim should be submitted on a CMS 1500 professional claim form with the hospital's fee-for-service NPI. NDC reporting on the claim follows the same process as the UB-04, with a N4 prefix, NDC number without hyphens, unit of measurement, and corresponding revenue code. See CMS 1500 excerpt claim example below:

	24. A. DATE(S) O	F SERV	/ICE To DD		B. PLACE OF SERVICE	C. EMG	D. PROCEDURE (Explain Unu CPT/HCPCS		i)	E. DIAGNOSIS POINTER	F. S CHARGES	G. DAYS OR UNITS
1	N40033800490		orphin 01	e Sul		jectio	n ML1000			Α	20 00	
2												
Q												

Scenario 4: Partial Hospitalization Services

In this scenario, a patient presents for outpatient partial hospitalization services. There is no APL procedure code present in this situation and the services are billed on a UB-04 as Bill Type 132. Partial Hospitalization Program (PHP) services must be billed with Revenue Code 0912 with a HCPCS code of S9480. A series bill can be submitted for this scenario if the patient is receiving PHP services on multiple days. It is important that hospitals ensure the correct NPI and taxonomy codes are used. The hospital must use the General Acute Care hospital NPI and provider type 030, must be registered for Categories of Service 027 or 028, and must use the psychiatric unit taxonomy code (273R00000X). See claim example on the following page.

Claim Example 1: Partial Hospitalization Services



H. FAQs

When is an authorization required for Outpatient Services?

Answer: Prior authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require authorization are identified by each MCO and may differ. A Summary of Authorization information by MCO can be found here.

VI. Inpatient Hospital (General Acute Care and Children's Hospital)

A. Purpose

The purpose of this section is to outline policies and procedures for hospitals billing for inpatient services.

B. Provider Type

This section applies to General Acute Care Hospitals and Children's Hospitals. For a List of HFS Registered Children's Hospitals see Appendix A.

Inpatient Services are 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.

NPIs

Both General Acute Care and Children's Hospitals are required to register their NPIs as a Provider Type 30 - General Acute Care Hospital for inpatient billing.

Categories of Service:

Below are the allowable inpatient Categories of Services (COS) for institutional NPI billing:

020 Inpatient Hospital Services (General)

021 Inpatient Hospital Services (Psychiatric)

022 Inpatient Hospital Services (Physical Rehabilitation)

023 Inpatient Hospital Services (ESRD)

Although COS is not directly added to an MCO claim, the COS and taxonomy combination that is registered in the HFS Provider IMPACT system is critical to accurate claims payment. If the appropriate COS is not registered, claims will deny.

Reporting of Hospital NPIs

1. Hospitals registered with only General Acute Care Hospital NPIs

- General Acute Care Hospital NPI is to be used for all members regardless of age.
- Newborn Claims (APR-DRG 626 or 640) for members less than 18 years of age on the date of admission will be billed using the General Acute Care NPI and submitted with the appropriate taxonomy:
 - 282NC2000X (General Acute Care Hospital Children)
 - 281PC2000X (Chronic Disease Hospital Children)
 - 282NW0100X (General Acute Care Hospital Women)

- 282N00000X (General Acute Care Hospital)
- 282NR1301X (General Acute Care Hospital Rural)
- Newborn Claims (APR-DRG 626 or 640) for members over the age of 18 years on the date of admission will be billed using the General Acute Care NPI and submitted with the appropriate taxonomy:
 - 282N00000X (General Acute Care Hospital)
 - 282NR1301X (General Acute Care Hospital Rural)
 - 282NR1301X (General Acute Care Hospital Rural)
- Hospitals may submit fee-for-service claims, using the General Acute Care NPI, for the following services performed in the hospital inpatient setting:
 - Long Acting Reversible Contraception after delivery
- Claims will be submitted using the General Acute Care Hospital NPI for the following Inpatient COS:
 - 021 Inpatient Hospital Services (Psychiatric)
 - 022 Inpatient Hospital Services (Physical Rehabilitation)
- If the General Acute Care Hospital NPI is registered in IMPACT for COS 021 (Psychiatric) and/or COS 022 (Rehabilitation), the provider may submit claims using the General Acute Care Hospital NPI.
- If the General Acute Care Hospitals' NPI is **not** registered in IMPACT for COS 021 (Psychiatric), the provider may submit a claim for emergency psychiatric care using the 282N00000X (General Acute Care Hospital) taxonomy.
- If the General Acute Care Hospital's NPI is **not** registered for one of the following Category of Services, then the provider may not submit a claim for reimbursement for the following Inpatient COS (with the exception of emergency psychiatric services as noted above):
 - 021 Inpatient Hospital Services (Psychiatric)
 - 022 Inpatient Hospital Services (Physical Rehabilitation)

The following must be billed under the registered General Acute Care Hospitals' NPI:

- Category of Service is 20 or 23 and:
 - DRG code is in the range 370 through 384; or
 - DRG code is 391; or
 - o APR-DRG is 540, 541, 542, 544, 545, 546, 560, 561, 563, 564, 565, 566, 626 or 640
- Category of Service is 24,25 or 26 and:
 - Primary ICD-9 diagnosis code in the range of 630 through 677 or V22, V23 or V28, for the equivalent principle ICD-10 Diagnosis codes see Appendix C.
- 2. Hospitals Registered with Multiple NPIs (separate General Acute & Children's Hospital):

The following information denotes how the allowable Hospital Inpatient Categories of Services (COS) are to be billed for providers who have both a registered General Acute Care and Children's Hospital NPIs. For a list of HFS registered Children's Hospitals see Appendix B.

i. General Acute Care Hospital NPI - over the age of 18 years on the date of admission

General Acute Care Hospital NPI **must always** be used for members over the age of 18 years on the date of admission for the following inpatient COS:

- 020 Inpatient Hospital Services (General)
- 023 Inpatient Hospital Services (ESRD)
- For inpatient COS 021 (Inpatient Hospital Services Psychiatric) and 022, (Inpatient Hospital Services Physical Rehabilitation), note the following important requirements:
 - Hospitals must be registered in IMPACT for these COS and will bill using the General Acute Care Hospital NPI.
- If the General Acute Care Hospital NPI is registered for Category of Service 21 (Psychiatric) and/or Category of Service 22 (Rehabilitation), the provider must submit claims using the General Acute Care Hospital NPI.
- If the General Acute Care Hospitals' NPI is **not** registered for Category of Service 21 (Psychiatric), the provider may submit a claim for emergency psychiatric care.
- If the General Acute Care Hospitals' NPI is <u>not registered</u> for one of the following Category of Services, then the provider <u>may not submit a claim</u> for reimbursement (except for emergency psychiatric care as noted above):
- 021 Inpatient Hospital Services (Psychiatric)
- 022 Inpatient Hospital Services (Physical Rehabilitation)
- Labor and Delivery Claims (APR-DRG 540, 541, 542, 544, 545, 546, 560, 561, 563, 564, 565 or 566) for members over the age of 18 years on the date of admission **must be billed using the General Acute Care NPI** and the appropriate taxonomy code:
- 282N00000X (General Acute Care Hospital)
- 282NR1301X (General Acute Care Hospital Rural) or
- 282NW0100X (General Acute Care Hospital Women)
- Hospitals may submit fee-for-service claims, using the hospital's General Acute Care NPI, for the following services performed in the hospital inpatient setting:
- Long Acting Reversible Contraception after delivery
- The following must be billed under the registered General Acute Care Hospital NPI:
- Category of Service is 20 or 23 and;
- DRG code is in the range 370 through 384; or
- DRG code is 391; or
- APR-DRG is 540, 541, 542, 544, 545, 546, 560, 561, 563, 564, 565, 566, 626 or 640
- Category of Service is 24, 25 or 26 and:
- Primary ICD-9 diagnosis code in the range of 630 through 677 or V22, V23 or V28 for the equivalent principle ICD-10 Diagnosis codes see Appendix C;

- For additional information on Guidelines Specific to General Acute Care and Children's Hospital Billing Guidelines for Hospitals with Multiple NPIs also see Appendix B.
- ii. Children's Hospital NPI less than the age of 18 years on the date of admission

Children's Hospital NPIs **must always** be used for members less than the age of 18 years on the date of admission (with the exception of Labor and Delivery) for the following inpatient COS:

- 020 Inpatient Hospital Services (General)
- 023 Inpatient Hospital Services (ESRD)

Newborn Claims (APR-DRG 626 or 640) for members less than the age of 18 years on the date of admission must be billed using the General Acute Care NPI and the appropriate taxonomy code from the following list:

- 282NC2000X (General Acute Care Hospital Children)
- 281PC2000X (Chronic Disease Hospital Children)
- 282NW0100X (General Acute Care Hospital Women)
- 282N00000X (General Acute Care Hospital): or
- 282NR1301X (General Acute Care Hospital Rural)
- Claims **may not** be submitted using the Children's Hospital NPIs for the following inpatient COS **unless** the provider's Children's Hospital NPI is *specifically registered* in IMPACT for the allowable Categories of Services.
- 021 Inpatient Hospital Services (Psychiatric)
- 022 Inpatient Hospital Services (Physical Rehabilitation)
- In scenarios where the Children's Hospital NPI is not registered for the aforementioned COS, then the General Acute Care Hospital NPI may be used for patients under the age of 18 at admission, if the hospital is registered for the respective COS (e.g. psychiatric services).

Claim are to be submitted using the appropriate taxonomy:

- 283XC2000X (Rehabilitation Hospital Children)
- 273R00000X (Psychiatric Unit)
- 283Q00000X (Psychiatric Hospital) or
- 283X00000X (Rehabilitation Hospital)

If *neither* the Children's Hospital nor the General Acute Care Hospitals' NPI is registered for COS 21 (Psychiatric), the provider may submit a claim for emergency psychiatric care by billing with the General Acute Care Hospital NPI and using the 282N00000X (General Acute Care Hospital) taxonomy.

The following may never be billed under the registered Children's Hospital NPI:

- COS 20 or 23 and:
- Primary ICD-9 diagnosis code is in the range of 290 through 302 or 306 through 319 for the
 equivalent principle ICD-10 Diagnosis codes see Appendix C, DRG code is in the range 370
 through 384; or

- DRG code is 391
- APR-DRG's 540, 541, 542, 544, 545, 546, 560, 561, 563, 564, 565, 566, 626 or 640

General Acute Care and Children's Billing Guidelines

General Acute Care & Children's Billing Guidelines on the following page illustrates the appropriate taxonomies for claim submissions relative to a properly billed NPI for a provider's allowable Category of Service.

Age Restrictions	Services	APR DRG/COS	Hospital Type	Billing NPI/ Medicaid ID	Taxonomies	Taxonomy by Age
Beneficiaries 18 years old and over	Labor and Delivery	APR DRG = 540, 541, 542, 544, 545, 546, 560, 561, 563, 564, 565 or 566	Children's and General Acute	Only General Acute Hospital NPI/ID	282N00000X (General Acute Care Hospital) 282NW0100X (General Acute Care Hospital - Women)	18 and over
Beneficiaries under the age of 18	Labor and Delivery	APR DRG = 626 or 640	Children's and General Acute	Only General Acute Hospital NPI/ID	282NC2000X (General Acute Care Hospital - Children) 281PC2000X (Chronic Disease Hospital - Children) 282N00000X (General Acute Care Hospital) 282NR1301X (General Acute Care Hospital - Rural)	Under 18
All Beneficiaries	Labor and Delivery	APR DRG = 626 or 640	Stand-Alone Children's	Children's Hospital NPI/ID	282NC2000X (General Acute Care Hospital - Children) 281PC2000X (Chronic Disease Hospital - Children) 282N00000X (General Acute Care Hospital) 282NR1301X (General Acute Care Hospital - Rural)	All Ages
Beneficiaries 18 years old and over	General Acute care	Inpatient COS = 020, 023 Outpatient COS = 024,025,026	Children's and General Acute	Institutional NPI/ID	282N00000X (General Acute Care Hospital) 282NW0100X (General Acute Care Hospital - Women)	18 and over
Beneficiaries under the age of 18	General Acute care	Inpatient COS = 020, 023 Outpatient COS = 024,025,026	Children's and General Acute	Children's Hospital NPI/ID	282N00000X (General Acute Care Hospital) 282NW0100X (General Acute Care Hospital - Women) 282NC2000X (General Acute Care Hospital - Children) 281PC2000X (Chronic Disease Hospital - Children)	Under 18
All Beneficiaries	General Acute care	Inpatient COS = 020, 023 Outpatient COS = 024,025,026	General Acute Only	Institutional NPI/ID	282N00000X (General Acute Care Hospital) 282NW0100X (General Acute Care Hospital - Women) 282NC2000X (General Acute Care Hospital - Children) 281PC2000X (Chronic Disease Hospital - Children)	18 and over Under 18

Age Restrictions	Services	APR DRG/COS	Hospital Type	Billing NPI/ Medicaid ID	Taxonomies	Taxonomy by Age
Beneficiaries under the age of 18	Psych	Inpatient COS = 021 Outpatient COS = 027,028	Childrens and General Acute	** Childrens Hospital NPI/ID	273R00000X (Psychiatric Unit) 283Q00000X (Psychiatric Hospital)	All Ages
Beneficiaries 18 years old and over	Psych	Inpatient COS = 021 Outpatient COS = 027,028	Childrens and General Acute	General Acute Hospital NPI/ID	273R00000X (Psychiatric Unit) 283Q00000X (Psychiatric Hospital)	All Ages
All Beneficiaries	Psych	Inpatient COS = 021 Outpatient COS = 027,028	General Acute Only	Institutional NPI/ID	273R00000X (Psychiatric Unit) 283Q00000X (Psychiatric Hospital)	All Ages
Beneficiaries under the age of 18	Rehab	Inpatient COS = 022 Outpatient COS = 029	Childrens and General Acute	** Childrens Hospital NPI/ID	283XC2000X (Rehabilitation Hospital – Children)	Under 18
Beneficiaries 18 years old and over	Rehab	Inpatient COS = 022 Outpatient COS = 029	Childrens and General Acute	General Acute Hospital NPI/ID	283X00000X (Rehabilitation Hospital)	18 and over
All Beneficiaries	Rehab	Inpatient COS = 022 Outpatient COS = 029	General Acute Only	Institutional NPI/ID	283X00000X (Rehabilitation Hospital) 283XC2000X (Rehabilitation Hospital - Children)	18 and over Under 18

^{**} If Children's NPI is not registered for the allowable COS, must use General Acute NPI (only if registered).

C. Coding Guidance

General inpatient hospital services are defined as those services ordinarily provided by licensed general hospitals, such as medical, surgical, pediatric, orthopedic, maternity, intensive care services, etc.

Inpatient services are billed using the Institutional Claim formats which include the 837I electronic formats or UB-04 paper claim format.

i. Statement and Admission Dates

Statement covered days, also known as "From and Through" dates, must be the correct date that the member was admitted or when the services were rendered, as illustrated in the decision tree below:

- The Statement Covers Period ("From" and "Through" dates in FL 6) identifies the span of service dates included in a particular bill. The "From" Date is the earliest date of service on the bill.
- The "Through" date on an outpatient claim must not be after the admit date on an inpatient claim.
- The Admission Date (FL 12) is the date the patient was admitted as an inpatient to the facility (or indicates the start of care date for home health and hospice). It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill. On an interim continuing (XX3) or interim final (XX4) bill, the admit date must be prior to the statement covers "From" date.

The table below highlights common situations and how to indicate the statement covered dates:

IF	THEN						
Member was seen for only outpatient services on a single day.	Statement cover	Statement covered dates would be the same and no admission date would be billed.					
		From	Throug	gh Ad	lmission Date		
	03	0119	030119				
Member was first seen in the Emergency Department / Observation, then admitted later	Statement cover Emergency Department		•	ate would be	mber was first se the same. dmission Date	en in the	
that day and provider is billing a	030	119	030419	030	0119		
Member was first seen in the Emergency Department (ED)/		•	•		patient claim, one	•	
Member was first seen in the	claim containing All ancillary serv are reported on First Claim: Statement cover Emergency Deport Second Claim: Statement cover Admission date should be subm	the emerge ces related the inpatien ed dates wo interest / Observed day would would matchtted.	ncy room cha to the emerg t claim. Fuld include conservation wind d begin on the	narge or the o gency or obse only the days ith no admiss the next day n Correct and va	member was in toom department was in too date. member was admalid admission soo	charge on ent service he itted. urce code	
Member was first seen in the Emergency Department (ED)/ Observation, then admitted and provider is billing two separate	claim containing All ancillary serv are reported on First Claim: Statement cove Emergency Depo Second Claim: Statement cove Admission date should be subm	the emerge ces related the inpatien ed dates wo interest / Object day would would match tted.	ncy room chi to the emerg t claim. Fulld include conservation wind d begin on the that date. Comm	only the days ith no admiss the next day no Correct and value.	member was adm	charge on ent service he itted. urce code	
Member was first seen in the Emergency Department (ED)/ Observation, then admitted and provider is billing two separate	claim containing All ancillary serv are reported on First Claim: Statement cover Emergency Deport Second Claim: Statement cover Admission date should be subm	the emerge ces related the inpatien ed dates wo interest / Observed day would would matchtted.	ncy room cha to the emerg t claim. Fulld include conservation with the that date. Communication of the communicat	narge or the o gency or obse only the days ith no admiss the next day n Correct and va	member was in toom department was in too date. member was admalid admission soo	charge on ent service he itted. urce code	

EDI/ 837I Requirements for statement and admission dates:

- Admission date is required on ALL inpatient institutional bill types and should be no later than the "From" date on the initial provider claim.
- EDI claim placement = Loop 2300, DTP*435 in the DTP03 segment (No future dates):
 - (Claims require the "DT"- date/time format qualifier for all Inpatient, Hospice and Interim Inpatient claims, in the DTP- 02, and the date/Time in the CCYYMMDDHHMM format in the DTP03 segment).

Example with hours and minutes: DTP*435*DT*201705171205 **Example without hours and minutes:** DTP*435*D8*20170517

ii. Value Codes

All inpatient claims must report the covered and non-covered days.

Value codes vary and are comprised of two data elements; the value code and the amount.

They are used to report the following information (if applicable):

- Locator Code

- Other Insurance Payment
 - Medicaid Covered Days • Medicaid Non-Covered Days

- Rate Code
- Recurring Monthly Income Epogen Units
- Newborn Birth Weight

The following value codes are to be reported when required or applicable:

Value Code	Description
Value code 54 (Newborn Birth weight in grams)	Beginning with admissions October 1, 2014 and after, Value Code 54 is required for newborns who are 28 days of age or less on the date of admission. This Value Code is to be reported with the baby's birth weight in grams, right-justified to the left of the dollar/cents delimiter and will be used in the APR-DRG determination.
Value Code 68 (Epogen Units)	Value Code 68 must be used when Erythropoietin (Epogen) is billed under revenue codes 0634 or 0635 in addition to using the correct units of measurement.
Value Code 80 (Covered Days)	Value Code 80 must be used to indicate the total number of days that are covered. The Covered Days must be entered to the left of the dollars/cents delimiter.
	Value Code 81 must be used to indicate the total number of full days that are not reimbursable. Enter the actual number of Medicaid non-covered days to the left of the dollars/cents delimiter. An occurrence span code of 74 must also be billed in HI*BI segment (FL 35-36) to indicate a non-covered level of care or a leave of absence.
Value Code 81 (Non-Covered Days)	Aetna Better Health of Illinois specific instructions: Non-covered days or non-reimbursable days, should be billed with an appropriate revenue code, at a zero dollar amount OR the facilities billed charge amount.
	Meridian specific instructions: Non-reimbursable days include those not covered due to lack of authorization approval. Non-covered days should be billed with the corresponding revenue code at a zero-dollar amount for more accurate calculation of reimbursement.

iii. **Revenue Codes**

A valid HFS revenue code must be on the claim for it to be accepted by the MCO. On the UB-04 the Revenue Codes are located in FL 42.

HFS maintains a list of non-covered revenue codes. These codes *should not* be billed on an Illinois Medicaid claim. Billing with these codes will result in a claim rejection.

The list on non-covered revenue codes is located at the end of this section. You can also view by clicking <u>here</u>.

It is the expectations that the facilities bill with the generally accepted and appropriate revenue codes for the services being provided.

An example of revenue codes includes, but is not limited to:

Bed Type	Private Rev Code	Semi-Private Rev Code
Room & Board	0110	0120
Med/Surgical	0111	0121
ОВ	0112	0122
Psychiatric	0114	0124
Rehabilitation	0118	0128

iv. Covered and Non-Covered Days

All inpatient claims must report the covered and non-covered days.

The sum of covered and non-covered days must correspond to the Statement Covers Period in FL 6 and should not reflect the day of discharge.

It is allowed for providers to submit Statement Covers Period in FL 6 equal to the same dates (same 'Statement From' and 'Statement Through' date) on claims with one accommodation revenue code and the appropriate Value code 80 or 81 equal to 1.

When submitting claims that are reimbursed on a DRG basis, only report value code 80 as the total days of stay. Claims paid by Per Diem reimbursement should have the appropriate covered and non-covered days reported to match the authorization.

Meridian and Molina Only Requirement:

Meridian and Molina require the use of Condition codes:

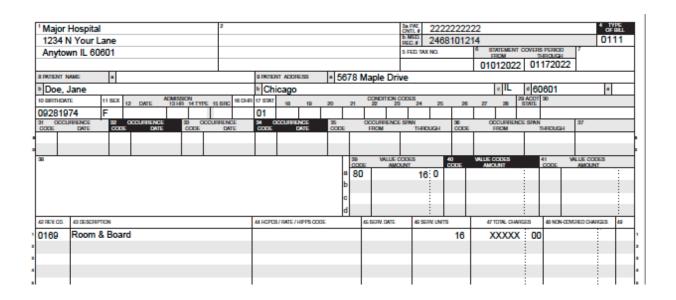
- C1 would be used if the entire stay was fully covered.
- C3 would be used when non-covered days were reported as well.
- Condition codes are required for the claim to process. The absence of these condition codes will result in a claim denial.

<u>Aetna Better Health of Illinois Only Requirement:</u>

For Aetna Better Health of Illinois, the sum of covered and non-covered days should be equal to or less than the Statement Covers Period in FL 6, not including date of discharge. See UB-04 examples below.

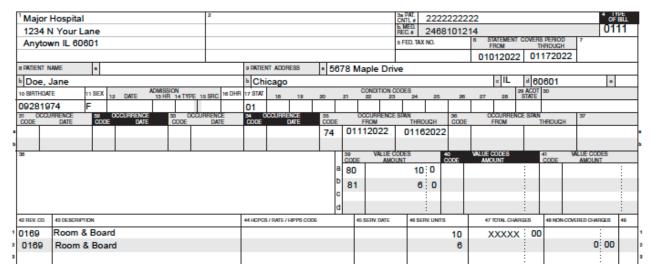
Example 1: Covered Days Only

Patient in-house from 1/1/22 thru 1/17/22. 16 covered days. Value code 80 amount and service line units are equal to or less than the statement from/through span.



Example 2: - Mix of Covered and Non-Covered (Per Diem Reimbursement)

Patient authorized for 10 day stay. Value Code 80 and 81 sum to amount equal to or less than the statement from/through date span.



Examples of how to report covered and non-covered days on hospital claims (EDI Requirements):

For example purposes, the following dates have been used: (e.g. 07/10/2017 – 07/19/2017)

- On claim level report total length of stay, which is service from to service thru
 - DTP*434*RD8*20170710-20170719
- Number of days of stay does not include day of discharge (DOS Thru Date DOS from Date)
 - Report non-covered dates on HI*BI segment with occurrence span code 74
 - HI*BI: 74:RD8:20170715-20170718

- Report covered and non-covered days on HI*BE segment with value code 80 for covered days and 81 for non-covered days
 - HI*BE:80:::5*BE:81:::4*BE:01:::19.29
- On service lines level, Units reported with accommodation revenue codes must be equal to total number of covered days
 - SV2*0120**9645*DA*4
 - DTP*472*RD8*20170710-20170719
 - LX*2
 - SV2*0202**4245*DA*1
 - o DTP*472*RD8*20170710-20170719
- For the following patient status codes, date of discharge is counted when patient is in deceased status. (DOS thru Date – DOS from Date) +1
 - o 20-29 Expired
 - 40 Expired at home
 - 41 Expired in medical facility (e.g. hospital, SNF, ICF, or free-standing hospice)
 - 42 Expired place unknown

v. 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.

Hospitals reimbursed with the DRG methodology cannot submit interim claims. A single claim for the entire period covering admit through discharge should be submitted. This is not the case if the COS changes during the inpatient stay. Two claims would then be submitted.

See Coverage and/or Service Changes During an Inpatient Stay below.

- Patient status 30 must be billed for interim claims
- If Bill frequency type code (On CLM Segment) is a 1 or 4 Do not calculate day of discharge in covered non-covered day calculations
- If Bill frequency type code is 2 or 3 Include day of discharge in covered non-covered day calculations.

Description below:

- 1. Admit through Discharge Claim = (DOS Thru Date DOS from Date)
- Interim-First Claim = (DOS Thru Date DOS from Date) +1
- 3. Interim Continuing Claim = (DOS Thru Date DOS from Date) +1
- 4. Interim-Last Claim= (DOS Thru Date DOS from Date)

Providers who are eligible to bill in an interim fashion should note the following:

- Services billed should be in one-month increments
 - Example 1: 3/1/19-3/31/19
 - Example 2: with an admit date of 2/6/19

- **2**/6/19-2/28/19
- If the patient is discharged, the gap must be shown as non-covered days (See Value Codes Section).

vi. Present on Admission (POA) Indicator

Present on Admission (POA) Indicator for the principal diagnosis code and every secondary diagnosis code on inpatient hospital claims is required.

The admitting diagnosis code, reported in FL69 on the UB-04 or Loop 2300, HI02, Qualifier BJ of the 837I, and E Code(s), reported in FL72a-c on the UB-04 or Loop 2300, HI03, Qualifier BN of the 837I **will not** require a POA indicator.

This requirement will apply to all inpatient services and all hospitals.

Reporting Options and Definitions:

- Y Yes (Present at the time of inpatient admission)
- N No (Not present at the time of inpatient admission)
- U Unknown (Documentation is insufficient to determine if condition is present at time of inpatient admission)
- W Clinically undetermined (Provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
- 1 Unreported/Not used Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not allowed in the 837I transaction).

837I Reporting of the POA Indicator

The POA data element on an electronic claim (837I) must contain the letters "POA" followed by a single POA indicator. The POA indicators will follow the diagnosis code in the appropriate 2300 HI segment per 5010 837I guidelines.

UB-04 Reporting of the POA Indicator

The "POA" indicator is reported in the eighth digit (shaded area) of FL67 for the principal diagnosis and in the eighth digit (shaded area) of FL67A-Q for each secondary diagnosis. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.

vii. Services to Newborn Children

MCOs require a separate inpatient claim form for the newborn in addition to the claim for the mother. Hospitals must send a Notification of Birth (NOB) to HFS. The newborn claim must include the newborn RIN. If the claim is received without the newborn RIN, the MCO will reject the claim.

Medicaid eligibility and RIN assignment is administered by HFS and is not a function of the MCOs. The provider should submit the claim only when eligibility has been established and a RIN has been assigned for the newborn.

The following guidance should be used in billing for newborn care:

For newborns who are added to Medicaid less than 46 days from the date of birth:

- Their eligibility date and birth date will be the same
- If mother is enrolled with the MCO on the newborn's date of birth, the newborn will be assigned to the same MCO and their eligibility will be *retroactive* to newborn's date of birth.
- Services are to be billed to the MCO

For newborns who are added to Medicaid 46 days to 364 days from date of birth:

- Mom is currently assigned to an MCO
- Infant will be assigned to the Mom's MCO
- Services provided from newborn's date of birth until date of eligibility should be billed to HFS
 as fee-for-service
- Services provided from date of eligibility forward can be billed to the MCO

Providers should check MEDI any day after Day 46 to verify where claim(s) should be directed (MCO vs. HFS).

viii. Coverage for Long-Acting Reversible Contraceptives (LARCs) in the Inpatient Setting

For inpatient discharges after July 1, 2020, the device charge should be included on the hospital inpatient claim. It will price as an add-on amount to the APR-DRG payment determined for the inpatient delivery. The current LARC codes that will prompt the add-on amount are J7296, J7297, J7298, J7300, J7301, and J7307.

ix. Coverage and/or Service Changes During an Inpatient Stay

Medicaid Coverage Changes during Inpatient Stay:

- For hospitals receiving DRG payments, the MCO that the member was assigned to on the date of admission is responsible for payment.
- For hospitals receiving per diem payments, MCOs are responsible only for the days that the member is enrolled and covered with their plan.

Changes in Service during an Inpatient Stay:

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.

Under Arrangements Billing

In those instances where an inpatient admitting hospital requires a service not available in the admitting hospital and the patient is transported to another facility for those services, the admitting hospital will assume billing for ALL services provided to that patient.

When submitting the inpatient claim, the hospital where the member is an inpatient, includes on its claim all the services it rendered to the member directly and it includes on its claim all the services that it arranged for the member to receive, on an outpatient basis, at another hospital, including all the costs involved. If the member is transported by ambulance to receive those services at another hospital, the inpatient hospital will report the cost of the transportation in with the cost for the appropriate ancillary service rendered by the second hospital. The inpatient hospital cannot bill for revenue code 0540 (transportation) on the inpatient claim. The amount that the inpatient hospital reimburses the second hospital and/or transportation provider is determined between the parties involved.

Example:

Member Smith is an inpatient at Hospital A and requires an MRI that Hospital A is not able to provide due to the patient's weight. Member Smith is transported to Hospital B for the MRI and returns back to Hospital A the same day. There is no discharge and re-admission because the MRI occurred within one day.

Hospital A will bill for <u>all</u> services (including the MRI) to Member Smith's MCO. Hospital B will <u>not</u> submit a claim to Member Smith's MCO, but will be reimbursed by Hospital A according to whatever arrangement the two hospitals have agreed upon.

x. Prior Authorization and Medical Necessity

A common denial for hospital services is "no authorization". It is critical that providers receive prior authorization for services as well as for inpatient days. MCO Prior Authorization requirements may differ.

Medical Necessity

The provider, in consultation with the MCO Medical Director and other clinical staff, is responsible for making utilization management decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Prior Authorization

Prior authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require authorization are identified by each MCO. Emergency Room (ER) and urgent care services **never** require prior authorization. Providers should notify the MCO of post-stabilization services. Notification and clinical information are required for ongoing care

and authorization of the services. Failure to obtain authorization may result in administrative claim denials.

For a summary of MCO requirements and processes related to authorizations see **General Claim Guidelines for All Providers**.

D. Other

UB04/837i Institutional Claim Reminder Items:

Below is a summary of items to pay close attention to when submitting Inpatient Claims. This is not meant to be an all-inclusive list.

Topic	Reminder
Patient Status Code	On an Inpatient claim the patient status code at discharge must be on the claim 2300 Loop CL103. Reported on the UB-04 in box 17 Patient Status Code
Principle Procedure Code and Date	If a procedure is done, FL 80 must be reported on the UB04. On the 837I: - HI01-1 = BBR and HI01-2 should be ICD-10 principle procedure code.
Missing Covered Days	All Inpatient or series billable claims must be submitted with Value code 80/amount
Incorrect/Missing Non- covered days	Inpatient claims will reject if the Statement 'From Date' and 'Through Date' for Occurrence Span Code 74 doesn't match with the Non-Covered Days Value Code submitted, or when Value code 81/amount is not submitted for the days that were not covered.
Accommodation Days are not equal to covered days.	Total accommodation days billed must match the total covered days or the claim will reject.
Service units greater than covered days.	Claims will reject if the sum of Service Units in claim line level is greater than or not equal to Covered days value code 80 amount(s).
Procedure Date Outside Per Diem Range	The Procedure Date must be within the From and Through dates on the inpatient claim.
	Hospital services for abortions must be billed with the abortion "AH" condition code. Information on the expansion for abortion services can be found here .
Abortion Condition Code	Effective 11/1/2019 the submission of abortion claims has changed. All abortion claims for services need to be submitted to HFS directly. This pertains to both Health Choice Illinois members and traditional fee for service members. Details can be found here-new-members and traditional fee for service members. Details can be found here-new-members and traditional fee for service members. Details can be found here-new-members and traditional fee for service members. Details can be found here-new-members and traditional fee for service members. Details can be found here-new-members and traditional fee for service members.
Invalid Interim Claim	An interim claim was received from a DRG Hospital for general inpatient and must be billed for the entire period covering admit through discharge.

VII. Custom Orthotic, Prosthetic and Pedorthic Services

A. Purpose

The purpose of this section is to outline current policies and procedures for billing custom orthotics, prosthetics, and pedorthic (OPP) services.

B. Provider Type

This section applies to registered orthotists, prosthetists and pedorthists licensed under the Orthotics, Prosthetics and Pedorthics Practice Act (225 ILCS 84/10). The accredited OPP facilities that employ these Illinois licensed OPP practitioners must be registered in the State's IMPACT system.

NPIs

OPP providers are required to register their NPIs as Provider Type 063 in HFS' IMPACT system (Other Providers of Medical Equipment/Supplies).

Categories of Service

The allowable Categories of Service (COS) for the NPI billing is 041 (medical equipment/custom prosthetic/orthotic devices).

Taxonomies

335E00000X or 332B00000X

Although COS is not directly added to a claim submitted to a MCO, it is critical that the provider's HFS IMPACT record is registered under the correct COS or the claim will deny.

C. Coding Requirements

Custom prosthetic and orthotic devices include corrective or supportive devices prescribed to artificially replace a missing portion of the body; to prevent or correct physical deformity or malfunction; or to support a weak or deformed portion of the body as defined in the Orthotic, Prosthetic, Pedorthic Practice Act (225 ILCS 84/10).

Date of service on the claim is the date of delivery to the patient. The device must be dispensed prior to charges being submitted. In the event of the death of a patient prior to delivery, or the patient's failure to maintain the delivery appointment within 60 days after notification that the device is completed and ready for delivery, providers should contact the individual MCO for guidance on whether or how a claim can be submitted.

Services should be billed on a CMS 1500 or an 837P electronic format. For minimum claim requirements and timely filing deadlines for Plans, see Introduction - Minimum Claim Requirements.

The following table outlines the most common custom OPP billing codes. Please ensure all appropriate prior authorizations are obtained before submitting a claim. Information on the Prior Authorization process by MCO can be found by clicking here.

PLEASE NOTE: MCOs follow the HFS limitations on quantities listed in the <u>DME/OPP fee schedule</u>. An asterisk (*) in the PAIR column indicates one *pair* (one left and one right). A (2) in the PAIR column indicates that Plans will pay for two (2) pairs when medically necessary and with prior authorization. If the item on the DME fee schedule has an * in the PAIR column, then the provider should bill <u>one</u> line for the item with a quantity of 1 (indicating one (1) pair). If the item on the HFS DME fee schedule has "2" in the PAIR column, then the provider should bill the line item with 1 for the item with a quantity of 1.

Type of Service	Description	Provider Type	HCPCS Codes
Custom Prosthetic	Lower Extremity (LE)	IL Licensed Prosthetist	L5000-L5999
Custom Prosthetic	Upper Extremity (UE)	IL Licensed Prosthetist	L6000-L7499
Prosthetic	Prosthetic Supplies		L8400-L8499
Custom Orthotic	Cranial/Cervical	IL Licensed Orthotist	L0112-L0200
Custom Orthotic	Thoracic (TLSO) TLSO Additions	IL Licensed Orthotist	L0220-L0651 L1200-L1290

Type of Service	Description	Provider Type	HCPCS Codes
Custom Orthotic	Cervical/Thoracic	IL Licensed Orthotist	L0700-L0861
Custom Orthotic	Scoliosis/Cervical Scoliosis Procedure Spinal Ox - Replace Girdle	IL Licensed Orthotist	L1000-L1120 L1300-L1310 L4000
Custom Orthotic	Hip Orthosis (HO)	IL Licensed Orthotist	L1600-L1690
Custom Orthotic	Legg Perthes Orthosis	IL Licensed Orthotist	L1700-L1755
Custom Orthotic	Knee Orthosis (KO)	IL Licensed Orthotist	L1830-L1860
Custom Orthotic	Ankle Foot Orthosis (AFO)	IL Licensed Orthotist	L1900-L1990
Custom Orthotic	Hip Knee Ankle Foot (HKAFO)	IL Licensed Orthotist	L2000-L2090
Custom Orthotic	Replace Orthotic Parts	IL Licensed Orthotist	L4002-L4210
Custom Orthotic	Walking Boots	IL Licensed Orthotist	L4350-L4631
Custom Orthotic	Fracture Orthosis	IL Licensed Orthotist	L2106-L2192
Custom Orthotic	Lower Ext Ox Additions	IL Licensed Orthotist	L2200-L2999
Orthotics	Upper Ext Orthotics Truss Device	OT/IL Licensed Orthotist	L3650-L3999 L8300-L8330
Custom Pedorthics	Custom Foot Orthotic	IL Licensed Orthotist/Pedorthist	L3010
Custom Pedorthics	Diabetic Shoes/Inserts	IL Licensed Orthotist/Pedorthist	A5500-A5514
Custom Pedorthics	Custom Foot Orthotic	IL Licensed Orthotist/Pedorthist	L3010
Custom Pedorthics	Diabetic Shoes/Inserts	IL Licensed Orthotist/Pedorthist	A5500-A5514

Miscellaneous Codes

The following codes are considered "hand-priced codes" according to the HFS DME fee schedule. Each MCO will price these differently, so providers should consult their individual contracts for guidance. The following codes will require authorization and full documentation/description of the device.

Type of Service	Description	HCPCS Code
Spinal orthosis & additions	Not otherwise specified	L0999 & L1499
Lower Extremity Orthotic	Not otherwise specified	L2999
Upper Limb Orthotic	Not otherwise specified	L3999
Lower Extremity Prosthetics	Not otherwise specified	L5999
Upper Extremity Prosthetics	Not otherwise specified	L7499
Unlisted Prosthetic Service	Unlisted Procedure for misc.	L8499
Custom Lymphedema garments		S8422-S8426
Custom Compression garments		A6549
Custom Burn garments/masks		A6501-A6513
Repair Orthotic/Replace Minor Parts		L4210
Repair Prosthetic/Replace Minor Parts		L7510

VIII. Supportive Living Facility (SLF)

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Supportive Living Facilities (SLF).

B. Provider Type

The Supportive Living Section applies to provider type 028.

C. Supportive Living Facility (SLF) Eligibility

- A Medicaid recipient must be assessed and their determination of need (DON) must be approved to qualify for the Supportive Living Facility waiver. The DON is completed by the Illinois Department on Aging.
- The Managed Care Organizations (MCO) do not determine eligibility for waiver services/ Supportive Living Facility.
- While HFS determines eligibility for services, many MCO's set up authorizations to ensure only HFS approved members receive waiver services.

D. IMPACT Enrollment Requirements

There are two specific enrollment options available to providers in the HFS IMPACT system for provider type 028, Supportive Living Facility.

They include:

- Alzheimer/Dementia Center
- Assisted Living Facility

The approved categories of service in HFS IMPACT system include:

- Alzheimer/Dementia Center
 - 86 LTC SLF Dementia Care (Waivers)
- Assisted Living Facility
 - 87 LTC Supportive Living Facility (Waivers)

E. Patient Credit File

The Patient Credit File (PCF) is submitted to Managed Care Organizations (MCOs) weekly by the Department of Healthcare and Family Services (HFS). The PCF incorporates data regarding eligible services rendered to a MCO's membership for a rolling 36-month period. It is composed of individual member segments, each of which relay the following information:

- Recipient Identification Number (RIN)
- Last Name
- First Name
- LTC Provider ID

- Hospice Provider ID (Conditional)
- Patient Credit Segment Begin Date
- Patient Credit Segment End Date
- Patient Credit Amount

- Exceptional Care (COS 038) (Conditional)
- Exceptional Care Segment Begin Date (Conditional)
- Exceptional Care Segment End Date (Conditional)
- Provisional Eligibility Indicator (Conditional)

The PCF is a MCO's source of truth for validation.

- HFS notifies the MCOs of patient income responsibilities via the weekly patient credit file (PCF)
 - The member and SLF provider must both be on the patient credit file for provider to receive payment.
 - All SLF claims are reviewed for patient liability using the patient credit file and payment to SLF providers will be reduced should the member have income liability during the month of service.

F. Billing Requirements

These billing requirements became effective 12/1/16.

All SLF claims must be billed in an electronic format using the HIPAA10 837i format.

1. Covered Services

- Revenue code 0240: All-inclusive Ancillary General Services
- Revenue code 0182: Leave of Absence Patient Convenience
- Revenue code 0183: Leave of Absence Therapeutic Leave
- Revenue code 0185: Hospitalization

2. Leave of Absence

Leave of absence revenue codes are reimbursed as follows:

- Days 1-30 reimbursable per state FY (July June)
- Days >30 not reimbursable per state FY (July June)

SLF's receive a total of 30 payable LOA days per fiscal year, regardless of type. Those LOA days are payable at 100% of the daily rate. Any LOA days exceeding 30 should be priced at \$0.00. 0185 days are included in the payable LOA count.

SLFs are not permitted to bill for LOA days while a resident is on a short tem stay at a nursing facility. If a resident goes to a NF, the SLF should submit a discharge transaction via MEDI, which will then cause an end date to appear on the PCF. Plans will not pay for any dates outside of the PCF date range. Once the resident returns to the SLF, a new admission should be submitted.

3. Billing Cycle

All SLF services should be billed in one-month increments using the following examples:

• Example 1: 3/1/19-3/31/19

- Example 2: with an admit date of 2/6/19
 - o 2/6/19-2/28/19
- Example 3: with a discharge date of 2/20/19
 - o 2/1/19-2/20/19

Key Data Field Explanations and Requirements:

The chart below highlights the claim form claim requirements and explanations. Billing guidelines describe form locator fields on a UB04 as a point of reference only. As noted above, all SLF claims must be billed in an electronic format using the HIPAA10 837i format.

Form Locator Field	Explanation	Completion Needed	Comments
01	Provider Name	Required	
02	Pay-To Name and Address Required if different the pay to NPI is different than the Billing Provider	Conditional	
04	Type of Bill	Required	4-digit code required 089X X= 1 for admit through discharge X=2 first claim in a series (discharge status = 30) X=3 ongoing series claims (discharge status = 30) X=4 final series claim (discharge status not equal to 30) X=7 for corrected claim
05	Federal Tax ID	Required	
06	Statement Covers Period	Required	Billed in no more than a 1-month increment
12	Admission Date	Optional	
17	Patient Discharge Status	Required	Examples include but are not limited to: 01= Discharge to home or self-care 03= Discharged to a Skilled Nursing Facility 20= Expired (patient died) 30=Still a patient
31-34	Occurrence Code	Conditional	
35-36	Occurrence Span Code	Conditional	74 only when billing a LOA Must have a LOA revenue code on the claim 018x
44	HCPCS/Accommodation Rates	Required	
45	Service Date	Required	When there is a LOA, must group service dates, rev codes, together when consecutive

Form Locator Field	Explanation	Completion Needed	Comments
46	Service Units	Required	Each unit is defined as a calendar day and should match the billed units in the span/day
47	Total Charges (By Rev Code Category)	Required	
48	Non-Covered Charges	Conditional	
50	Payer	Required	Name of Managed Care Organization
51	Health Plan Identification Number	Conditional	Not applicable for SLF
54 A, B	Prior Payments	Conditional	Not applicable for SLF
56	NPI of Billing Provider	Required	NPI of the Billing SLF Provider
57	Other (Billing) Provider Identifier	Optional	HFS legacy provider number
58	Insured's Name	Required	Member's name as it appears in MEDI
60	Recipient ID number	Required	MCO member id
64	Document Control Number	Conditional	If submitting a corrected claim, include the previous claim number here
67	Principle Diagnosis Code and Present on Admission Indicator	Required	Enter the ICD-10 code Present on Admission is NOT required for SLF
67 A-Q	Other Diagnosis Codes	Conditional	If multiple Dx on the claim, ok to include
69	Admitting Diagnosis Code	Required	ICD-10 code
72 A-C	External Cause of Injury	Conditional	Include the ICD-10 when there is an external cause of injuries, poisoning, or adverse effect
76	Attending Provider Name and NPI	Required	Include the NPI of the attending provider
81	Taxonomy Number	Required	COS 86 Dementia Care: 311500000X COS 87 SLF (Waivers): 310400000X

IX. Long-term Care/ Skilled Nursing Facility

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Long-term Care/ Skilled Nursing Facility providers.

B. Provider Type

The Long-term Care/ Skilled Nursing Facility section applies to provider type 033 which includes skilled nursing facilities, intermediate care facilities, and general acute hospital LTC wing.

C. Long Term Care (LTC) Eligibility

- A Medicaid recipient must be assessed and their determination of need must be approved to qualify for long term care
- The MCOs do not determine eligibility for long term care services
- While HFS determines eligibility for services, many MCOs have a notification or authorization requirement related to the admittance to the facility.
- Exceptional care approval is determined by the state
 - Member must be approved for exceptional care
 - Provider <u>must</u> be enrolled with category of service 038 to provide/bill exceptional care
 - Exceptional care is on the patient credit file with approved providers/dates

D. IMPACT Enrollment Requirements

Provider must be Enrolled in HFS IMPACT system as provider type 033

- Skilled Nursing Facility
- Nursing Facility/Intermediate Care
- General Acute Care Hospital LTC Wing

The approved categories of service in IMPACT may include:

- 070 LTC-Skilled
- 071 LTC Intermediate
- 038 Exceptional Care
- 065 LTC Full Medicare Coverage
- 072 LTC-NF/Skilled/Coinsurance (partial Medicare coverage)
- 083 Developmental Training (not covered by MC plans at this time)

E. Patient Credit File

The Patient Credit File (PCF) is submitted to Managed Care Organizations (MCOs) weekly by the Department of Healthcare and Family Services (HFS). The PCF incorporates data regarding eligible services rendered to a MCO's membership for a rolling 36-month period.

It is composed of individual member segments, each of which relay the following information:

- Recipient Identification Number (RIN)
- Last Name
- First Name
- LTC Provider ID
- Hospice Provider ID (Conditional)
- Patient Credit Segment Begin Date
- Patient Credit Segment End Date
- Patient Credit Amount
- Exceptional Care (COS 038) (Conditional)
- Exceptional Care Segment Begin Date (Conditional)
- Exceptional Care Segment End Date (Conditional)
- Provisional Eligibility Indicator (Conditional)

The PCF is a MCO's source of truth for validation.

- HFS notifies the MCOs of patient income responsibilities via the weekly patient credit file (PCF).
 - The member and the LTC provider (and when applicable, the hospice provider and Exceptional Care Approval) must be on the patient credit file in order for the provider to receive payment.
 - All LTC claims are reviewed for patient liability using the patient credit file and the payment to LTC providers will be reduced should the member have income liability on the date of service.
 - Days reported on the PCF do not include the last day of a stay unless discharge was due to death.

F. Billing Requirements

- All LTC claims must be billed in an electronic format using the HIPAA 5010 837i
- Billing guidelines describe form locator fields on a UB04 as a point of reference

1. Covered Services

- Revenue codes 0110-0160: General room and board (except 0115, 0125, 0135, 0145 or 0155)
- Revenue codes 0191-0193: Exceptional care for TBI Levels 1-3
- Revenue code 0194: Exceptional care for Vent
- Revenue code 0182: Leave of Absence Patient Convenience
- Revenue code 0183: Leave of Absence Therapeutic Leave
- Revenue code 0185: Hospitalization

2. Leave of Absence

Leave of absence revenue codes are not reimbursable although it is required that you bill for those days, the reimbursement will be \$0.00.

3. Billing Cycle

- Claims should not be held by providers. Always submit the claim within the appropriate cycle for processing.
- Payment for long term care services is on a per diem basis. In determining the number of
 days for which payment can be made, the day of admission to the facility is counted. The
 day of discharge from the facility is not counted, unless it is the day of death and death
 occurs in the facility or a reserved bed has been authorized for that day.
- Services billed should be in one-month increments
 - Example 1: 3/1/19-3/31/19
 - Example 2: with an admit date of 2/6/19
 - **2**/6/19-2/28/19
 - Example 3: with a discharge date of 2/20/19
 - **2/1/19-2/20/19**
- If a member transfers to a different level of care within a facility (e.g. moves to skilled care for a portion of the month), two separate claims using the appropriate bill type must be submitted. Dates of service for the two claims must not overlap.
 - Example (for member admitted to facility on 7/1/22)
 - Claim for intermediate care for the first 15 days of the month:
 - Statement Period: 11/01/22 11/15/22
 - Bill Type: 0653
 - Admit date on claim: 7/01/22
 - Discharge date on claim: 11/15/22
 - Value Code 80 = 15
 - Revenue Code 0120 = 15
 - Claim for skilled care for last 15 days of the month:
 - Statement Period: 11/16/22 11/30/22
 - Bill Type: 0213
 - Admit date on claim: 7/1/22
 - Discharge date on claim: 11/30/22
 - Value Code 80 = 15
 - Revenue Code 0120 = 15

For providers with Managed Long-Term Services and Supports (MLTSS) membership residing in their facilities, one-month incremental billing is not always required due to Medicare components on the claim. Covered days from received claim information will be handled as follows:

- Medicaid covered services must be billed to the MCO.
- Medicare covered services must first be billed to Medicare and then may be submitted to Medicaid after the adjudication of the Medicare claim.

4. Key Data Field Explanations and Requirements

The chart below highlights the claim form claim requirements and explanations.

Key Data Field Explanations and Requirements

Form Locator Field	Explanation	Completion Needed	Comments
01	Provider Name	Required	
02	Pay-To Name and Address Required if different the pay to NPI is different than the Billing Provider	Conditional	
04	Type of Bill	Required	 4-digit code required Different series based on level of care 021X: Skilled Nursing (can be used in hospital LTC wing) 022X: Skilled Nursing Inpatient Part B 065X: Intermediate Care 079X: Training (outpatient setting) 011X Hospital Inpatient (hospital LTC wing only) X= 1 for admit through discharge X=2 first claim in a series (discharge status = 30) X=3 ongoing series claims (discharge status not equal to 30) X=7 for corrected claim
05	Federal Tax ID	Required	
06	Statement Covers Period	Required	Billed in no more than a 1-month increments
12	Admission Date	Required	If bill type ends in 1, statement from date and admit date <u>must</u> match. If bill type ends in 2, statement from date and admit date <u>must</u> match. If bill type ends in 3 or 4, statement from date and admit date <u>cannot</u> match and must be the original admission date.
17	Patient Discharge Status	Required	Examples include but are not limited to: 01= Discharge to home or self-care 03= Discharged to a Skilled Nursing Facility 20= Expired (patient died) 30=Still a patient
31-34	Occurrence Code	Conditional	A2 – Effective Date of Policy (First Day of Medicaid) A3 – Benefits Exhausted (Last Day of Medicare) B3 – Benefits Exhausted – Payer B (Last Day of Medicare) 22 – Date Active Care Ended (Last Day of Medicare) 25 – Date Benefits Terminated by Primary Payer (First Day of Medicaid)
35-36	Occurrence Span Code	Conditional	70 only when billing Skilled Nursing Inpatient (including Medicare Part A) 74 only when billing a LOA Must have a LOA revenue code on the claim 018X

Form Locator Field	Explanation	Completion Needed	Comments
			80 = must equal "covered days" 81 = any non-covered days 82 = coinsurance days (Medicare claims only)
			Example 1: 3/1-3/31/19 No LOA days, therefore value code 80 should be reported with a unit value of 31
39-41	Value Codes	Required	Example 2: 3/1-3/31/19 5 LOA days, therefore value code 80 should be reported with a unit value of 26 and value code 81 should be reported with a unit of 5 and the required Occurrence Code and/or Occurrence Span Code Both scenarios created a total of 31 units
			Example 3: Admit date 3/1-3/29/19 and no LOA Value code 80 should be reported with 29 units
			3A: 03/01-03/29 with bill frequency 4 and discharge status 20 would have a value code 80 reported with 29 units
			3B: 03/01-03/29 with bill frequency 4 and discharge status 03 would have a value code 80 reported with 28 units.
		(0115, 0125, 0135, 0145 or 0155) Rev code 0191-0193 = Exceptional care TBI Rev code 0194= Exceptional care VENT Rev code 0182 = LOA for patient convenience Rev code 0183 = LOA for therapeutic leave Rev code 0185= Hospitalization Use Rev Code 0110-0160 for each day the member in the facility. Total units of this series should equa units for value code 80. The exceptional care reven	Rev code 0191-0193 = Exceptional care TBI Rev code 0194= Exceptional care VENT Rev code 0182 = LOA for patient convenience Rev code 0183 = LOA for therapeutic leave
42	Revenue Codes		Use Rev Code 0110-0160 for each day the member was in the facility. Total units of this series should equal the units for value code 80. The exceptional care revenue codes will count toward the value code 80 calculation
			In order for the exceptional care services to be reimbursed, the provider must be enrolled with a category of service 038 and the member must be approved to receive exceptional care services.
			Use Rev Code 018X for all LOA days, and the total should equal the unit of value code 81.
43	Revenue Code Description	Required	
44	HCPCS/Accommodation Rates	Optional	
45	Service Date	Required	When there is a LOA, must group service dates, rev codes, together when consecutive.
46	Service Units	Required	Each unit is defined as a calendar day
47	Total Charges (By Rev Code Category)	Required	
48	Non-Covered Charges	Conditional	
50	Payer	Required	Name of Managed Care Organization
51	Health Plan Identification Number	Conditional	

Form Locator Field	Explanation	Completion Needed	Comments
54 A,B	Prior Payments	Conditional	
56	NPI of Billing Provider	Required	NPI of the Billing LTC Provider
57	Other (Billing) Provider Identifier	Optional	HFS legacy provider number
58	Insured's Name	Required	Member's name as it appears in MEDI
60	Recipient ID number	Required	MCO member id
64	Document Control Number	Conditional	If submitting a corrected claim, include the previous claim number here
67	Principle Diagnosis Code and Present on Admission Indicator	Required	Enter the ICD-10 code Present on Admission is NOT required for LTC
67 A-Q	Other Diagnosis Codes	Conditional	If multiple diagnosis on the claim, ok to include
69	Admitting Diagnosis Code	Required	ICD-10 code
72 A-C	External Cause of Injury	Conditional	Include the ICD-10 when there is an external cause of injuries, poisoning, or adverse effect
76	Attending Provider Name and NPI	Required	Include the NPI of the attending provider
81	Taxonomy Number	Required	314000000X = Skilled Nursing 313M00000X = Intermediate Care Facility 282N00000X = General Acute Hospital (LTC wing)

X. Hospice

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Hospice providers.

B. Provider Type

The Hospice Section applies to provider type 039.

C. Hospice Eligibility

To comply with state requirements in 42 CFR Part 418 and HFS administrative rules at 89 Illinois Administrative Code Section 140.69, all Hospice providers **must complete and submit to HFS the Hospice Notice of Election Form (HFS Form 1592)**.

HFS Form 1592

- Hospice Notice of Election Form is required for all new hospice segments.
- A copy of the Hospice Notice of Election Form should be sent to the MCO.
 - Benefit periods consist of two ninety (90) day benefit periods

HFS Form 1593

HFS Form 1593 must be submitted to HFS for continuing benefits and recertification of terminal illness. Benefit periods consist of 60-day benefit periods. The HFS Form 1593 must be submitted every 60 days.

HFS Form 1594

When a member dies or is discharged from hospice HFS Form 1594 must be completed.

Other Form Notes:

- If a new hospice election occurs after the HFS Form 1594 has been submitted to HFS, a new HFS Form 1592 must be submitted to HFS.
- If a patient transfers from one hospice provider to another, the discharging hospice provider must submit the HFS Form 1594, and the new hospice provider must submit the HFS Form 1592.

Provisional Eligibility

Provisional Eligibility is authorized for a person whose admission transaction to a LTC facility pends over 45 days, and the person has either 1) an active medical case or 2) a pending medical application over 45 days old.

- Individuals with Provisional Eligibility will be treated the same as those with Regular Medicaid Eligibility.
- Hospice can bill for Room and Board for recipients with Provisional Eligibility.
- Individuals determined ineligible for Medicaid LTC services will also have their LTC admission segment closed.
- Providers will retain payments made under the Provisional Eligibility time frames.

D. IMPACT Enrollment Requirements

Provider must be a registered provider of hospice services in the HFS IMPACT system with provider type 039.

The approved categories of service in the HFS IMPACT system may include:

- 060 Home
- 061 Inpatient
- 062 Continuous Nursing
- 063 Respite

E. Billing Requirements

- Covered services include:
 - Revenue code 0651: Routine Home Care
 - Revenue code 0652: Continuous Home Care
 - Revenue code 0655: Inpatient Respite Care

- o Revenue code 0656: General Inpatient Care
- Revenue code 0657: Physician Services
- Revenue code 0658: LTC Room & Board
- o Revenue code 055x: Registered Nurse Service: Service Intensity Add-on
- Revenue code 056x: Social Work Services: Service Intensity Add-on
- All hospice claims are to be billed on an institutional claim (UB04/837I)
 - All hospice services must have a service line date
 - UB04 Billing: These services are reimbursed on a per-day basis, providers may combine the total number of days for one revenue code on one line showing the beginning service date in FL 45 and the total number of days/units in FL 46, as long as the service dates are consecutive.
 - If the services dates are not consecutive, providers need to split the dates for that revenue code on a separate service line rather than combining the days on one line.
- Hospice Services and room and board must be billed on the same claim 0658 (room and board) and 0651 (hospice) must be billed together on the same claim
- The hospice claim will be subject to the Patient Credit File process described below in section f.
- If a LTC claim and a hospice claim with 0658 are received and both have dates of service in the same month, patient liability will be applied to the first claim processed, any remaining patient liability dollars, will be applied to the second claim processed. Note- LTC Claims require electronic filing.
- For members with Medicare Part A, the hospice provider must bill Medicare for the hospice care and physician services
 - Room and board charges (0658) are to be submitted to the MCO
 - Room and board charges are only reimbursable for individuals in a LTC facility. The MCO does not pay the room and board charges for individuals in a Supportive Living Facility as this is a non-covered benefit.
- Revenue code 055x Registered Nurse Service and 056x Social Work Services: Service Intensity Add-on:
 - May be billed when there is a visit from a social worker or registered nurse within the last 7 days of life
 - Service is payable in 15-minute increments (1 unit per 15 minutes)
 - Maximum allowed units = 16 (4 hours)
 - This is a combination of 055x and 056x
 - Registered Nurse = Revenue Code 055x plus HCPCS code G0299
 - Social Worker = Revenue code 056x plus HCPCS code G0155
 - Must be billed on individual service dates on the claim and not a range
 - Patient discharge status is 20 = deceased

Example of Split Billing

When a patient expires within the first 6 days of a new month and Service Intensity add -on is within the last 7 days of life in the prior month.

Example: Patient expires on 4/3/19

- Claim 1: 3/28 3/31 = Patient status "still a patient"
- Claim 2: 4/1 4/3 = Expired

In this example, claim 2 will pay with the Service Intensity add-on if the occurrence code 55 with the date of death is included, however, claim 1 which has already been processed will not include the add-on. There is not an automated process to allow the add-on to be paid for Claim 1. Providers should submit a corrected Claim 1 with an occurrence code of 55 and an occurrence date equal to the date of death to allow for the Service Intensity add-on to be processed.

If first claim has not been billed prior to the patient's death, the provider should indicate the date of death using occurrence code 55 and occurrence date and it should be present on both claims.

PLEASE NOTE: If the hospice provider is billing for both routine hospice and the LTC revenue code 0658 claims must be billed together, on the same claim.

F. Patient Credit File

- Recipient Identification Number (RIN)
- Last Name
- First Name
- LTC Provider ID
- Hospice Provider ID (Conditional)
- Patient Credit Amount
- Segment Begin Date
- Segment End Date
- Member Provisional Status
- Exceptional Care Indicator
- Exceptional Care Begin Date
- Exceptional Care End Date

The PCF is a MCO's source of truth for validation.

- Any claim billed with revenue code 0658 will be validated against the Patient Credit File (PCF), which supplies member liability specifically related to revenue code 0658.
- If the member, LTC provider, and/or hospice provider are not on the PCF, the claim will be denied, until HFS adds the member/provider/hospice provider.
- Member liability will be applied to the claim based on the information supplied on the HFS Patient Credit File.

G. Value Codes

Value codes for Hospice claims assist in determining the appropriate base rate.

The base rate is to be reported on the claim form using Value Code (see chart below fields 39 –
 41) and the Core-Based Statistical Area (CBSA)

- Base rates are based on the county in which services were provided using the geographic location referred to as CBSA
- Each CBSA is assigned a wage index
- The CBSA value can be found on HFS <u>website</u>.

Key Data Field Explanations and Requirements:

Fields identified will reference the UB04 for display purposes only, all MCO's require X12 layout compliance when electronic claims are submitted. Electronic submission is required.

Form Locator Field	Explanation	Completion Needed	Comments
01	Provider Name	Required	
02	Pay-To Name and Address Required if different than the billing provider in FL 1	Conditional	
04	Type of Bill	Required	4-digit code required 08XY X= 1 for non-hospital based X=2 for hospital based Y= 1 for admit through discharge Y=2 first claim in a series (discharge status = 30) Y=3 ongoing series claims (discharge status = 30) Y=4 final series claim (discharge status not equal to 30) Y=7 for corrected claim
05	Federal Tax ID	Required	
06	Statement Covers Period	Required	Billed in no more than a 1-month increment
12	Admission Date	Required	Date hospice started or date member entered LTC facility If bill type ends in 1, statement begin date and admit date <u>must</u> match If bill type ends in 2, statement begin date and admit date <u>must</u> match If bill type ends in 3 or 4, statement begin date and admit date <u>cannot</u> match
17	Patient Discharge Status	Required	01= Discharge to home, revoked, decertified 30=Still a patient 20=Expired 40=Expired at home (to be used for LTC claims 41=Expired at medical facility 42=Expired place unknown
31-34	Occurrence Code	Conditional	27=Date of certification or recertification 42=Date of revocation 55=Date of death (when patient status = 20,40,41,42) Occurrence code 55 and the date of death must be reported on all claims for which SIA charges are made. If the SIA crosses months, the claim from the proceeding the month the patient died and the claim for the month the death occurred.
35-36	Occurrence Span Code	Conditional	74=Non-covered date spans

Form Locator Field	Explanation	Completion Needed	Comments
39-41	Value Codes	Required	80=must equal covered days 81=any non-covered days G8=plus CBSA code where services were rendered for inpatient services (rev code 0655/0656) (right justified and to the left of the dollar/cent delimiter) 61=plus CBSA code in location of where services were rendered for routine home care or continuous home care (rev codes 0651 and 0652). Right justified and left of the dollar/cents delimiter 66= spend down liability with a dollar amount
42	Revenue Codes	Required	Services can be billed in a span except for 652, 055x and 056x Revenue code 0651: Routine Home Care Revenue code 0652: Continuous Home Care Revenue code 0655: Inpatient Respite Care Revenue code 0656: General Inpatient Care Revenue code 0657: Physician Services Revenue code 0658: LTC Room & Board
43	Revenue Code Description	Required	
44	HCPCS/Accommoda tion Rates	Required	For 055x report code G0299 For 056x report G0155 For 0657 report associated HCPCS/CPT code
45	Service Date	Conditional	All hospice services require a service line date. As long as the dates are consecutive, may combine the total number of days for one revenue code on one line showing the beginning service date. Total number of days in FL 46 (as long as the days are consecutive).
46	Service Units	Required	Rev code 055X is reported in 1/4-hour units Rev code 056x is reported in 1/4-hour units Rev code 0651 is reported in calendar days Rev code 0652 is reported in 1/4-hour units Rev code 0655 is reported in calendar days Rev code 0656 is reported in calendar days Rev code 0657 is reported as the number physician visits associated with the HCPCS code bill Rev code 0658 is reported in calendar days
47	Total Charges (By Rev Code Category)	Required	For Rev code 0001 see FL42 Includes covered and non-covered charges
48	Non-Covered Charges	Conditional	Reflects any non-covered charges pertaining to the related revenue codes
50	Payer	Required	Name of MCO (payer of last resort)
51	Health Plan Identification Number	Conditional	Only if there is a third-party source it is required provider bill the 3-digit TPL code and 2-digit status code TPL Codes can be found here . The TPL Status Codes are: 01 – TPL Adjudicated – total payment shown 02 – TPL Adjudicated – patient not covered 03 – TPL Adjudicated – services not covered 05 – Patient Not Covered 06 – Services Not Covered 07 – Third Party Adjudication Pending

Form Locator Field	Explanation	Completion Needed	Comments
			08 – Estimated Payment
54 A,B	Prior Payments	Conditional	Prior payment is only required for TPL
56	NPI of Billing Provider	Required	NPI of the Billing Hospice Provider
57	Other (Billing) Provider Identifier	Optional	HFS legacy provider number
58	Insured's Name	Required	Patient Name as it appears in MEDI
60	Recipient ID number	Required	MCO member id
64	Document Control Number	Conditional	If submitting a corrected claim, include the previous claim number here
67	Principle Diagnosis Code and Present on Admission Indicator	Required	Enter the ICD-10 code Present on Admission is NOT required for Hospice
67 A-Q	Other Diagnosis Codes	Conditional	Enter ICD-10 codes without the decimal
69	Admitting Diagnosis Code	Required	ICD-10 code without the decimal
72A-C	External Cause of Injury	Conditional	Include the ICD-10 (without the decimal) when there is an external cause of injuries, poisoning, or adverse effect
76	Attending Provider Name and NPI	Required	Include the NPI of the attending provider
81	Taxonomy Number	Required	Hospice Non-Hospital Community (bill type 081x) = 251G00000X Hospice Inpatient (bill type 082x) = 315D00000X

XI. Federally Qualified Health Centers, Rural Health Centers and Encounter Rate Clinics

A. Purpose

The purpose of this section is to outline current policies and procedures for billing by Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Encounter Rate Clinics (ERCs). For the purposes of simplification, this manual will use the term "encounter clinic" to refer to all three types of clinics, unless otherwise specified.

B. Provider Type

All providers, including encounter clinics, must be registered in the State's IMPACT system.

Encounter clinics must be enrolled as one of the provider types below:

- Provider Type 040: Federally Qualified Health Center (FQHC)
- Provider Type 048: Rural Health Clinic (RHC)
- Provider Type 043: Encounter Rate Clinic (ERC)

C. Taxonomies, Categories of Service and Place of Service

i. Taxonomy Codes

Appropriate FQHC/RHC/ERC Taxonomy Codes are listed by Provider Type below:

Provider Type 040 (FQHC)—261QF0400X

- Provider Type 048 (RHC)—261QR1300X
- Provider Type 043 (ERC)—261QP2300X

NOTE: Always ensure that if you have multiple NPIs and IMPACT Medicaid IDs that they match on the claim. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, etc.

ii. Category of Service

The taxonomy code used must match a corresponding Category of Service (COS), Procedure Code (PC) and/or Place of Service (POS). A crosswalk of taxonomies with COS, PC and POS is available here.

Appropriate FQHC/RHC/ERC Categories of Service (COS) for CMS1500/837P billing are listed in the table below.

Provider Type	Acceptable Categories of Service
040 FQHC	002 Dental Services
	010 Visiting Nurse Services
	026 General Clinic Services
	030 Healthy Kids Services
	058 Social Work
	059 Psychologists
	067 Maternal and Child Health Application
	088 Licensed Clinical Professional Counselor or Licensed Marriage & Family Therapist
	102 Fluoride Varnish
	104 Long Acting Reversible Contraceptives (LARCs)*
048 RHC	002 Dental Services
	010 Visiting Nurse Services
	026 General Clinic Services
	030 Healthy Kids Services
	058 Social Work
	059 Psychologists
	067 Maternal and Child Health Application
	088 Licensed Clinical Professional Counselor or Licensed Marriage & Family Therapist
	102 Fluoride Varnish for Children under 36 mos.
	104 Long Acting Reversible Contraceptives (LARCs)*
043 ERC	002 Dental Services
	026 General Clinic Services
	030 Healthy Kids Services
	067 Maternal and Child Health Application
	102 Fluoride Varnish for Children under 36 mos.

^{*}These should be billed as fee-for-service. Click here to view the Encounter Claims Crosswalks.

iii. Place of Service

The acceptable place of service codes for encounter clinics (billing the T1015 code) are:

02 – Telehealth provided other than in Patient's Home (distant site only)	15 - Mobile Unit/Clinic
03 - School based clinics with SB or SL specialty on their provider file.	31 - Skilled Nursing
	Facility
10 – Telehealth rendered to Patient located in their home (distant site	32 - Nursing Facility
only)	
11 - Office	33 - Custodial Care Facility
12 - Home	49 - Independent Clinic
13 - Assisted Living Facility	50 - FQHC
14 - Group Home	72 - Rural Health Clinic

^{*} if providers are billing FFS (i.e. not a T1015 code), another POS may be applicable.

Click <u>here</u> to view the POS, COS, PROC document.

D. Billable Services

i. Charges

Providers may only bill the MCO after the service or item has been provided. The clinic (FQHC/RHC/ERC) will be reimbursed at an all-inclusive rate established by HFS at the start of the calendar year for the type of encounter service rendered, except when billing allowable fee-for service charges listed below.

ii. Definition of Encounter

Encounter services must be rendered in a clinic, patient's home or long-term care facility if the facility is the patient's permanent place of residence, or school if the clinic has a school-based or school-linked specialty. Only one medical encounter per patient per day can be billed to the Department. If the clinic is enrolled for dental or behavioral health services, only one dental and one behavioral health encounter per patient per day is eligible for reimbursement.

A billable encounter is defined as one of the following:

- Medical encounter: Medical face-to-face visit with a physician, physician assistant, or Advance Practice Nurse.
- Behavioral health encounter: Behavioral health face-to-face visit with a licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist.
- Dental encounter: Dental face-to-face visit with a dentist or dental hygienist performed under the general supervision of a dentist.

IMPORTANT NOTE: Services and supplies (including drugs and biologicals, which are usually self-administered by the patient) furnished as an incident to a billable medical, behavioral or dental encounter, of kinds which are commonly furnished in the practitioners' offices and are commonly either rendered without charge or included in the practitioners' bills, are considered a component of the encounter and cannot be billed as fee-for-service. Examples of these services include, but are not limited to:

- Injections (allergy, antibiotic, steroids, etc.)
- Medical case management
- Patient transportation
- Health education
- Nutrition services
- Onsite laboratory tests:
 - o chemical examination of urine by stick or table method or both
 - hemoglobin or hematocrit
 - blood sugar
 - examination of stool specimens for occult blood
 - pregnancy tests
 - primary culturing for transmittal to certified labs

iii. Telehealth

Telehealth is the use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications.

The telecommunication system must, at a minimum, have the capability of allowing the consulting practitioner to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs. Telephones, facsimile machines, and electronic mail systems are not acceptable telecommunication systems.

Telehealth services include telemedicine, as well as telepsychiatry. Group psychotherapy is not a covered telepsychiatry service.

Originating Site (Patient Site)

The Originating Site is the site where the patient is located. An encounter clinic serving as the Originating Site shall be reimbursed their medical encounter. The Originating Site encounter clinic must ensure and document that the Distant Site provider meets the MCO's requirements for telehealth and telepsychiatry services since the clinic is responsible for reimbursement to the Distant Site provider.

- Telemedicine A physician or other licensed health care professional must be present with the patient at the originating site when medically necessary as determined by the physician or practitioner at the distant site.
- Telepsychiatry A physician, licensed health care professional or other licensed clinician, mental health professional, or qualified mental health professional must be available at all times at the originating site.

Distant Site (Provider Site)

The Distant Site is the site where the provider rendering the telehealth service is located.

For telemedicine services, the provider rendering the service at the Distant Site can be a physician, podiatrist, advanced practice nurse (APN), or a Physician Assistant (PA) who is licensed by the State of Illinois or by the state where the participant is located.

For telepsychiatry services, the provider rendering the service at the Distant Site must be a physician licensed by the State of Illinois, or by the state where the patient is located, who has completed an approved general psychiatry residency program or a child and adolescent psychiatry residency program. Telepsychiatry is not a covered service when rendered by an APN or PA. Group psychotherapy is not a covered telepsychiatry service.

iv. Group Psychotherapy

Group psychotherapy services must be directly performed by one of the following practitioners:

- Physician licensed to practice medicine in all its branches who has completed an approved general psychiatry residency program or is providing the service as a resident or attending physician at an approved or accredited residency program.
- Advanced Practice Nurse (APN) holding a current certification in Psychiatric and Mental Health Nursing.
- Licensed Clinical Psychologist (LCP).
- Licensed Clinical Social Worker (LCSW).
- Licensed Clinical Professional Counselor (LCPC).
- Licensed Marriage and Family Therapist (LMFT).

Group psychotherapy services rendered by a physician or qualified APN can be billed as a medical encounter.

Services rendered by a LCP, LCSW, LCPC or LMFT must be billed as a behavioral health encounter.

Group psychotherapy is not covered for participants who are residents in a facility licensed under the Nursing Home Care Act (210 ILCS 45) or the Specialized Mental Health Rehabilitation Act (210 ILCS 48).

To be eligible for reimbursement the group psychotherapy session must meet all of the following requirements:

- Patient's medical record must indicate the person participating in the group session has been diagnosed with a mental illness. Entire group psychotherapy service is directly performed by the one of the practitioners listed in <u>Group Therapy</u>.
- Group size does not exceed 12 patients, regardless of payment source.
- Minimum duration of a group session is forty-five (45) minutes.
- Group session is documented in the patient's medical record by the rendering practitioner, including the session's primary focus, level of patient participation and the begin and end times of each session.

- Group treatment model, methods, and subject content have been selected on evidence-based criteria for the target population of the group and follows recognized practice guidelines for psychiatric services.
- Group session is provided in accordance with a clear written description of goals, methods, and referral criteria.

v. Tobacco Cessation Counseling

Tobacco cessation counseling services rendered to children through age 20 or to women age 21 and over who are pregnant or in their 60-day post-partum period, are eligible for reimbursement by the MCOs.

Pregnant women and women who are up to 60-day post-partum and age 21 and over have a maximum of three quit attempts per year, with up to four individual face-to-face counseling sessions per quit attempt. The 12 maximum counseling sessions include any combination of the billable procedure codes per year. Children through age 20 are not restricted to the maximum twelve counseling sessions.

These counseling sessions must meet the criteria of a face-to-face medical encounter. The patient's medical record must be properly documented with provider signature, and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources offered and follow-up instructions

vi. Lab Billing

Encounter clinics and physicians who have onsite laboratories may bill for the Global Service only when the tests are performed by their own laboratories. Otherwise these must be billed with the 26 (Professional Component) modifier.

E. Allowable Fee-for Service Billing

Certain services rendered by clinic/center staff practitioners can be billed fee-for-service.

i. Services rendered by clinic/center staff practitioners outside of the clinic/home setting

When services are rendered by clinic/center staff practitioners outside the clinic or home setting, the clinic cannot bill an encounter. These services must be billed fee-for-service under the rendering practitioner's or supervising physician's NPI, and with the applicable place of service code. An example of this would be a clinic/center staff physician seeing patients who are hospitalized.

ii. Long-acting Contraceptive Devices

When FQHC/RHCs purchase long-acting contraceptive devices (LARCs) the clinic can bill for the device fee-for-service. Charges must be submitted separately from the encounter. To the extent that the LARCs were purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC or RHC's actual acquisition cost with a UD modifier.

iii. Services Not Included in Cost Report

Services not included in the cost report used to calculate the clinic/center's all-inclusive rate may be billed fee-for-service. The clinic/center practitioner must be enrolled separately with IMPACT to provide the services.

For the services listed below the service must be billed under the rendering practitioner's or supervising physician's NPI with payment directed to the clinic/center's corporate NPI.

The services will be reimbursed based on the HFS's applicable rate or the provider charge, whichever is less.

- Audiology services.
- Chiropractic services.
- Occupational therapy.
- Optometric services.

- Physical therapy.
- Podiatric services.
- Speech and hearing services

F. Coding Requirements

i. General Coding Information

Be sure to follow the **General Claim Submission Guidelines** for all providers at the front of this billing manual to ensure clean claim submissions.

Claims will be rejected or denied if billed with:

- missing, invalid, or deleted codes
- codes inappropriate for the age or sex of the member
- an ICD-10 CM code missing any 4th, 5th, and 6th character requirements and 7th character extension requirements
- inappropriate/incorrect taxonomy codes for provider

ii. Specific Encounter Clinic Billing Information

Claims must be submitted with the encounter CPT code (T1015 or S5190 for medical and D0999 for dental) listed in the first service line of the claim, along with the clinic's assigned encounter rate. When billing D0999, claims should be submitted to the MCO's dental provider, not the MCO directly (see Dental Encounter Section below for further details).

The CPT codes for the services rendered must then be listed in the remaining service sections as detail codes. The detail codes will be reimbursed at \$0.00.

Detail codes should include all services provided so long as they are provided as part of a billable encounter.

Procedure Code S5190

- Procedure code S5190 must be billed when a wellness assessment is performed by a nonphysician.
- S5190 is used instead of T1015 and cannot be billed on the same claim as T1015.
- S5190 is used for reporting purposes only and is not payable.
- Detail lines should still be reported when billing S5190.

Example: A vaccine given by a RN without a physician visit.

Behavioral Health Encounters

Behavioral Health Encounters should be submitted with the encounter CPT code (T1015) listed in the first service section along with the clinic's assigned behavioral health encounter rate. **Effective with dates of service beginning February 1, 2023,** behavioral health encounters should

be submitted with encounter CPT code **T1040 with the appropriate modifiers below.**

The CPT codes for the services rendered must then be listed in the remaining service sections as detail codes. The detail codes will be reimbursed at \$0.00.

Behavioral health encounters are limited to one visit per day. FQHCs and RHCs can bill for a medical encounter and behavioral health encounter for the same member on the same date of service. However, ERC payment policy does not allow for billing of both a medical and behavioral heath encounter on the same day of service.

Specific modifiers must be appended to the first service line (T1015) based on the rendering provider's Category of Service (COS):

- Licensed Clinical Social Worker
 - o COS 058
 - Bill T1015 with AJ modifier plus detail code
- Licensed Clinical Psychologist
 - o COS 059
 - Bill T1015 with AH modifier plus detail code
- Licensed Clinical Professional Counselor
 - o COS 088
 - o Bill T1015 with HO modifier plus detail code
- Licensed Marriage and Family Therapist
 - o COS 088
 - o Bill T1015 with HO modifier plus detail code

Dental Encounters:

Note the following requirements when submitting dental encounters:

- Claims must be submitted with D0999 for dental on the first service line of the claim.
- Submit one encounter claim for each unique member visit. Dental encounters are limited to one visit per day.
- Submit codes for every procedure performed on the encounter claim to ensure member utilization data are complete.
- Ensure every code includes corresponding tooth numbers, quads, arches and any other required identifiers.
- Include applicable authorization numbers.
- Include all documentation requirements.

Denture Billing:

An encounter clinic may bill up to three additional encounters per prosthesis for a member receiving a complete or partial denture. Partial dentures are limited to children age 2 through 20 only.

Use code D5899 – Unspecified Removable Prosthodontic Procedure – for eligible members receiving dentures in an encounter clinic. To receive consideration for additional reimbursement, a clinic must submit prior authorization for a maximum of three (3) procedure codes (D5899) along with authorization for the complete or partial denture. If the authorization for the complete or partial denture is approved, the clinic will also receive approval for up to three of the additional codes (D5899).

Appropriate Visits for Procedure Code D5899

- Initial denture impressions
- Final denture impressions
- Vertical dimension of occlusion visits
- Wax try in visits
- Necessary adjustments post insertion
- Repairs or relines during the six (6) month period following the insertion of the new prosthesis

In each case, a narrative of the service performed must be provided at the time procedure code D5899 is billed.

Providers should submit for payment for the complete or partial denture (D5110, D5120, D5211, D5212) at the time the prosthesis is inserted.

Telehealth Encounters

Telehealth Encounters when the clinic is the <u>Originating Site</u> should be submitted with the encounter CPT code (T1015) listed in the first service section along with the clinic's assigned encounter rate. Appropriate CPT codes for the services rendered must be billed in the remaining service sections. The detail codes will be reimbursed at \$0.00.

The Place of Service code for Telehealth claims must be the appropriate POS for the clinic type (e.g. 50 for FQHC's, 72 for RHCs) when clinic is the Originating Site. When the clinic is the Distant Site, POS 02 or POS 10 will be used, depending on the location of the patient. If the service is delivered via audio and video conferencing modifier GT should be used. If the service is delivered via audio conferencing only, the modifier 93 should be used.

If an encounter rate clinic is the Distant Site, there may or may not be a billable service. If there is a billable service (because the Originating Site is not another encounter clinic <u>or</u> the patient is located in their home), then the clinic billing the distant site service must use POS 02 or POS 10 respectively.

Telehealth billing examples:

a) Originating Site: Encounter Clinic

Bill the encounter HCPCS code T1015 and HCPCS code Q3014, along with any additional appropriate detail codes. POS code will match clinic type (e.g. 50 for FQHC). Maximum reimbursement will be the clinic's encounter rate.

Distant Site: Encounter Clinic

There is no billable service; the Originating Encounter Clinic is responsible for payment to the Distant Site provider.

b) Originating Site: Encounter Clinic

Bill the encounter HCPCS code T1015 and HCPCS code Q3014, along with any additional appropriate detail codes. POS code will match clinic type (e.g. 50 for FQHC). Maximum reimbursement will be the clinic's encounter rate.

Distant Site: Physician/APN/Podiatrist's Office

There is no billable service; the Originating Encounter Clinic is responsible for the payment to the Distant Site provider.

c) Originating Site: Physician/APN/Podiatrist's Office

Originating Provider will bill HCPCS code Q3014

Distant Site: Encounter Clinic

Bill the Encounter HCPCS code T1015 and any appropriate detail codes with (audio and video modality) or 93 (audio modality only) on the detail lines; POS is 02. Maximum reimbursement will be the clinic's encounter rate. The rendering provider's name and NPI must also be reported on the claim.

d) Originating Site: Patient in their Home

Distant Site: Encounter Clinic

Bill the Encounter HCPCS code T1015 and any appropriate detail codes with modifier GT (audio and video modality) or 93 (audio modality only) on the detail lines; POS is 10 (telehealth provided in Patient's Home). Maximum reimbursement will be the clinic's encounter rate.

iii. Vaccinations

Vaccination Billing:

Effective October 1, 2016 through August 31, 2019:

Vaccines for children (birth through age 18) eligible under the Title 21 and State-funded medical programs through the Department are not available through the Vaccines for Children (VFC) program. Clinics can bill vaccines for this population fee-for-service.

Children (birth through age 18) eligible under Title 19 must receive VFC vaccines when available through the VFC program. Title verification should always be performed through MEDI. For Title 19 children receiving vaccines through the VFC program:

- When a vaccine has been administered at a medical encounter, clinics must bill the T1015, medical encounter rate procedure code, the appropriate level evaluation and management procedure code, and the specific procedure code for the vaccine obtained through the VFC program.
- When a participant presents solely to receive a vaccine obtained through the VFC program at
 a clinic and a salaried staff member administers the vaccine (does not qualify as a billable
 encounter), the clinic should bill the S5190, Wellness Assessment encounter procedure code
 on line one and bill the specific procedure code for the vaccine obtained through the VFC
 program as a detail procedure code. The S5190 code is not reimbursed; however, the
 vaccine detail information is captured.

For Title 21 and state funded children:

- Clinics must bill private stock vaccine procedure codes with the GB modifier when administered as part of a billable visit with the encounter procedure code or when the participant presents solely to receive a vaccine at the clinic.
- When billing a private stock vaccine as part of an encounter or fee-for-service, clinics must enter a rate as a provider charge.

Effective September 1, 2019:

- Providers must use VFC vaccine on all children who are eligible for HFS medical programs regardless of title eligibility. Reimbursement is the clinic's encounter rate when there is a billable visit.
- Providers must still verify Title eligibility because the VFC program requires different stock to be used (DPH policy). Title eligibility does not affect reimbursement.

G. Submission Guidelines and Sample 1500 Forms

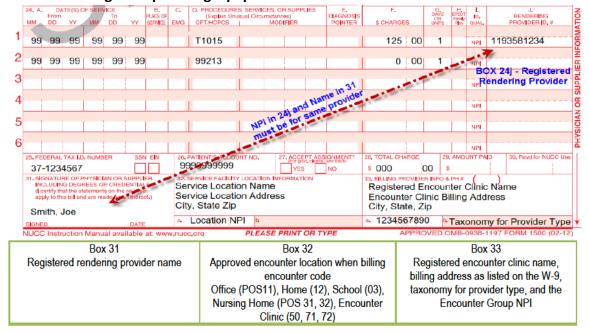
Encounter Rate Submission Guidelines:

Paper Claim CMS-1500	HIPAA 5010 837P Loop	HIPAA 5010 837P Segment	Encounter Reimbursement
Box 24b	2300	CLM05-1	Place of Service Code
Box 24f	2400	SV1-02	Encounter rate on initial service line billed with appropriate code, modifier if applicable, and amount. All subsequent service lines with zero dollars, per Section F(ii) above.
Box 24j	2310B	NM1-09	Site NPI or Registered Rendering Provider NPI*
Box 31	DOES NOT MAP IN THE 837	DOES NOT MAP IN THE 837	
Box 32	2310C	NM1	Location where approved encounter service was provided
Box 33	2010AA	NM108=XX NM109=NPI	Registered Encounter Clinic Organization Name (not site), billing address, NPI, and applicable taxonomy (as registered in IMPACT): 261QF0400X - FQHC (provider type 040) 261QP2300X - ERC (provider type 043) 261QR1300X - RHC (provider type 048) Per X12 EDI guidance NO P.O. Boxes or LOCK box permitted in this loop (2010AA)
Pay to Provider No field for this on CMS 1500	2010AB	NM1*87	Pay to Provider Address (P.O. Box or Lock Boxes acceptable in this loop) **

^{*} Aetna Better Health® of Illinois (IlliniCare), CountyCare and BCCHP REQUIRE the Registered Rendering Provider NPI. Do not use the Site NPI for Aetna Better Health and CountyCare. All other plans will accept either the Site NPI or the Registered Rendering Provider NPI.

^{**} FOR MOLINA: Pay to Provider address must exactly match the name provided on W-9 documents. If clinic uses a 3rd Party biller to receive payments, that address must be on the W9, and the vendor must be listed as a DBA.

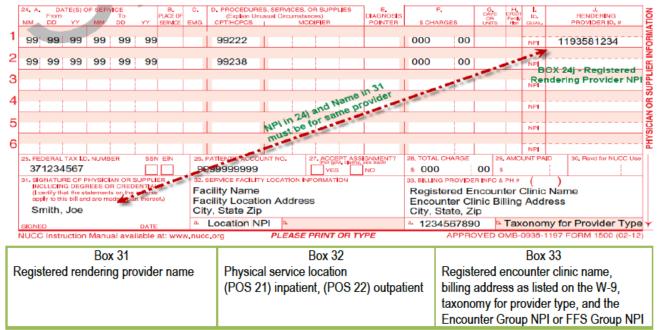
Encounter billing example using a paper CMS 1500:



Fee-for Service Submission Guidelines (requires the provider billing in Box 24j has access to practitioner fee schedule - e.g. labor and delivery at the hospital, provider completing an E&M for inpatient member):

Paper Claim CMS-1500	HIPAA 5010 837P Loop	HIPAA 5010 837P Segment	Encounter Reimbursement
Box 24b	2300	CLM05-1	Place of Service Code
Box 24f	2400	SV1-02	Bill the appropriate procedure code
Box 24j	2310B	NM1-09	Registered Rendering Provider NPI
Box 31	DOES NOT MAP IN THE 837	DOES NOT MAP IN THE 837	
Box 32	2310C	NM1	Location where approved service was provided
Вох 33	2010AA	NM108=XX NM109=NPI	Encounter Clinic Organization Name (not site), billing address, NPI, and Registered Rendering Provider taxonomy (as registered in IMPACT): Per X12 EDI guidance NO P.O. Boxes or LOCK box permitted in this loop (2010AA)
Pay to Provider No field for this on CMS 1500	2010AB	NM1*87	Pay to Provider Address (P.O. Box or Lock Boxes acceptable in this loop) *

Fee-for-Service billing example:



XII. Pediatric Services

A. Purpose

The purpose of this section is to outline policies and procedures for billing for pediatric services.

B. Provider Type

This section applies to pediatricians in private practice (i.e. not practicing in an FQHC or employed by a hospital). Pediatricians practicing in an FQHC, RHC or ERC should refer to that section of the manual.

Providers must have a valid NPI, be registered in the State's IMPACT system as Provider Type 010 or 016 with the appropriate and corresponding specialties and sub-specialties and include the correct taxonomy code on each claim. For further information, please refer to the Manual's Introduction, Provider Types/Category of Service/Taxonomy Codes.

C. Coding Requirements

Claims should be submitted on a CMS-1500 form or 837P format and follow all guidelines outlined in the Introduction section of this manual. Medicaid MCOs follow NUCC coding guidelines as well as those in Coding for Pediatric Preventive Care 2019 published by the AAP, except where noted in this manual.

Please find below tables of Procedure Codes common to pediatric services in use by Illinois Medicaid MCOs. Please note some of the codes will differ from the AAP guidelines.

TABLE 1: Procedure Codes Common to Healthy Kids Services

Procedure Description	Recommended CPT Code
Well Child Visit	
EPSDT Well Child Visit	99381-99385 (new patient - allowed once for any provider seeing patient for the first time) 99391-99395 (established patient) (use appropriate CPT code for the medical service provided) USE OF MODIFIER 25*: • When a well-child visit and a sick visit occur on the same day, Modifier 25 must be appended to the sick visit office E&M claim line. • Modifier 25 is also allowable for E&M HEDIS/EPSDT codes. Use of the modifier will unbundle some services as separate and distinct. It will not unbundle all line items on the claim.
Inter-periodic visits	Use appropriate Well Child Visit Code or Evaluation and Management Code - one inter-periodic visit is permitted per year
Dental Fluoride Varnish	D1206
Hearing	
Screening test, pure tone, air only	92551
Pure tone audiometry (threshold); air only	92552
Audiometry, air and bone	92553
Tympanometry (impedance testing)	92567
Otoacoustic emissions (OAE)	92558
Auditory brainstem response (ABR)	92586
Vision	
Visual function screening, automated or semi-automated, bilateral quantitative determination of visual acuity ocular alignment, color vision by pseudoisochromatic plates and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare)	99172 - Cannot be billed with 99393 or in addition to any other general ophthalmological service or an E&M code, per CPT guidelines
Screening test visual acuity quantitative, bilateral	99173**
ноту	99173**
Lea	99173**
Snellen	99173**
Ocular photo screening with interpretation and report, bilateral	99174
Lead Screening	
Blood lead analysis	83655
Collection of venous blood (venipuncture)	36415 U1 (blood lead draw)
Collection of capillary blood specimen	36416 U1 (blood lead draw)
Blood Lead Testing CLIA waived, Blood lead testing system (whole blood)	83655 QW

IMPORTANT NOTES:

- * Blue Cross Community Health Plan (BCCHP) and CountyCare DO NOT allow for well-child and sick visits on the same day.
- ** For MOLINA billing, this code will bundle when billed with general E&M services. Providers will need to add Modifier 25 for separate line item payment.

TABLE 2: Procedure Codes for Approved Risk Assessment Tools

* When two screening tests are performed at the same time (e.g. PHQ-9 and CRAFFT), providers should code 96127 with 2 units of service) *

Procedure Code	Recommended CPT Code			
Risk Assessment				
Problem-Oriented Screening Instrument for Teenagers (POSIT)	96127			
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Tool	96127			
Child and Adolescent Depression	96127			
Beck Depression Inventory-II (BDI-II)	96127			
Center for Epidemiological Studies Depression Scale (CES-D)	96127			
Center for Epidemiological Studies Depression Scale for Children (CES-DC)	96127			
Patient Health Questionnaire Adolescent Version (PHQ-A)	96127			
Patient Health Questionnaire Quick Depression Screen (PHQ-9)	96127			
Children's Depression Inventory (CDI)	96127			
Reynolds Adolescent Depression Scale (RADS)	96127			
Pediatric Symptom Checklist	96127			
Maternal (Perinatal) Depression				
Administration and Interpretation of health risk assessment (Postpartum Depression Screening)	96127 HD			
Prenatal care, at risk assessment (Prenatal Depression Screening)	H1000			
Edinburgh Postpartum Depression Scale (EPDS)	96127 HD			
Beck Depression Inventory-II (BDI-II)	H1000/96127 HD			
Center for Epidemiological Studies Depression Scale (CES-D)	H1000/96127 HD			
Patient Health Questionnaire Quick Depression Scale (PHQ-9)	H1000/96127 HD			
Parenting Stress Index (PSI)	H1000/96127 HD			
Adolescent Alcohol and Substance Use and Abuse				
Problem-Oriented Screening Instrument for Teenagers (POSIT)	96127			
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Tool	96127			

MODIFIER HD: Postpartum depression screening for the mother and billed using the child's RIN.

TABLE 3: Procedure Codes for Approved Developmental Screening Tools

^{*} When two screening tests are performed at the same time (e.g. ASQ and ASQ: SE), providers should code 96110 with 2 units of service) *

Tier 1: Developmental Screening and Assessment/Evaluation Tools - Approved for Reimbursement -	Recommended CPT Code						
Developmental Screening Tools							
Ages and Stages Questionnaires (ASQ)	96110						
Ages and Stages Questionnaire 4th Edition (ASQ-3)	96110						
Ages and Stages Questionnaire: Social-Emotional (ASQ : SE)	96110						
Battelle Developmental Inventory Screening Test (BDIST)	96110						
Bayley Infant Neurodevelopment Screener (BINS)	96110						
Bayley Scales of Infant and Toddler Development 4th Edition (Bayley- III - Screening Test)	96110						
Brief Infant Toddler Social and Emotional Assessment (BITSEA)	96110						
Brigance Early Childhood Screens (0-35 months, 3-5 years, K&1)	96110						
Chicago Early Developmental Screening Inventory	96110						
Developmental Profile II	96110						
Developmental Indicators for the Assessment of Learning - Revised (DIAL-R)	96110						
Developmental Indicators for the Assessment of Learning - 4th Edition (DIAL-3)	96110						
Early Language Milestone Scales Screen	96110						
Early Screening Inventory (ESI)	96110						
Early Screening Profiles (ESP)	96110						
Eyberg Child Behavior Inventory/Sutter-Eyberg Student Behavior	96110						
Family Psychosocial Screening	96110						
Infant Development Inventory (IDI)	96110						
Infant-Toddler Checklist for Language and Communication	96110						
Infant-Toddler Symptoms Checklist	96110						
McCarthy Screening Test (MST)	96110						
Modified Checklist for Autism in Toddlers (M-CHAT)	96110						
Minneapolis Preschool Screening Instrument (MPSI)	96110						
Parent's Evaluation of Developmental Status (PEDS)	96110						
Parent's Evaluation of Developmental Status-Developmental Milestones (PEDS:DM)	96110						
Parents' Observation of Infants and Toddlers (POINT)	96110						
Pediatric Symptoms Checklist (PSC)	96110						
Project Memphis DST	96110						
Revised Developmental Screening Inventory	96110						
Revised Parent Developmental Questionnaire	96110						
Safety Word Inventory and Literacy Screener (SWILS)	96110						
Temperament and Atypical Behavior Scale (TABS) Screener	96110						
Developmental Assessment/Evaluation Tools							
Achenbach Child Behavior Checklist - Preschool Module (ASEBA)	96112 for first hour (bill 1 unit only) 96113 for each add'l 30 minutes (limit of 6 units)						

Tier 1: Developmental Screening and Assessment/Evaluation Tools - Approved for Reimbursement -	Recommended CPT Code
Autism Diagnostic Observation Schedule (assessment only)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Battelle Developmental Inventory (BDI)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Bayley Scales of Infant and Toddler Development III	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Brigance Inventory of Early Development III Standardized (IED III)	96112 for first hour
	(bill 1 unit only)
CLILLD I (CDI)	96113 for each add'l 30 minutes (limit of 6 units)
Child Development Inventory (CDI)	96112 for first hour
	(bill 1 unit only)
Conneyla Rating Coolea (CRC)	96113 for each add'l 30 minutes (limit of 6 units) 96112 for first hour
Connor's Rating Scales (CRS)	
	(bill 1 unit only) 96113 for each add'l 30 minutes (limit of 6 units)
Developmental Assessment of Voung Children (DAVC)	96113 for each add 130 fillinates (lifting of 6 diffus)
Developmental Assessment of Young Children (DAYC)	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Devereux Early Childhood - Clinical Form	96112 for first hour
Devereux Earry Childridou - Chilicar Form	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Devereux Early Childhood Assessment for Infants and Toddlers	96112 for first hour
bevereux Early Childrigou Assessment for infants and roddlers	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Early Coping Inventory	96112 for first hour
Early coping inventory	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Erhardt Development Prehension Assessment (EDPA)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Hawaii Early Learning Profile (HELP)	96112 for first hour
, , ,	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Infant Toddler Developmental Assessment (IDA)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Infant-Toddler Social and Emotional Assessment (ITSEA)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Otis-Lennon School Ability Test (OLSAT)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Piers-Harris Children's Self-Concept Scale (PHCSCS)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Temperament and Atypical Behavior Scale (TABS) Assessment Tool	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Vineland Adaptive Behavior Scales (VABS)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Vineland Social-Emotional Early Childhood Scales (Vineland SEEC)	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)
Vineland Social Maturity Scale	96112 for first hour
	(bill 1 unit only)
	96113 for each add'l 30 minutes (limit of 6 units)

D. Services

i. Periodicity

MCOs follow the periodicity guidelines outlined in the HFS Healthy Kids Handbook.

ii. Vaccinations

Vaccinations provided **prior to** 8/31/19:

- For vaccines provided through the Vaccines for Children (VFC) program:
 - <u>Title 19 children</u>: providers must administer VFC vaccines and are eligible for reimbursement of the administrative fee
 - <u>Title 21 children and State Funded (SF) children</u>: providers must administer private stock vaccines and are eligible for reimbursement of administrative fee and the cost of vaccines administered
- Providers should screen the child for VFC eligibility or private purchase before administering vaccines. Children eligible under Title 21or SF must receive private stock vaccines.
- Providers are required to check VFC eligibility at the date of service and should save on file proof of the eligibility check
- MCOs will reimburse for vaccines administered to Title 21 and SF children in a setting other than an encounter rate clinic according to the table below:
- For children eligible under Title 21 and SF, MCOs will reimburse for vaccines as well as for the applicable evaluation and management codes shown above.
- Vaccinations can be administered during a sick visit when medically appropriate.
 Reimbursement will follow guidelines above.

Billing for Title XXI Vaccinations								
	Services to Bill							
Service Setting	Evaluation/Management Code	Vaccine Codes (State Max)						
During a Well Child Exam	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461,	90620, 90621, 90630, 90633, 90636, 90644, 90645, 90646, 90647, 90648, 90649, 90650, 90655, 90657, 90661, 90662, 90670, 90673, 90674, 90680, 90681, 90685, 90686, 90687, 90688, 90696, 90698, 90700, 90702, 90707, 90710, 90713,						
Stand-Alone Vaccination by Salaried Employee	99211	90714, 90715, 90716, 90721, 90732, 90732, 90734, 90743, 90744, 90747, 90748, Q2035, Q2036, Q2037, Q2038						

Effective **9/1/19**: providers will need to use VFC vaccine on all children regardless of Title eligibility.

- If providers use private stock vaccines, they will be reimbursed for the unit price as noted in the Practitioner Fee Schedule.
- Exception: Providers who have an OB/GYN specialty will be paid for private stock vaccine for the HPV vaccine. The provider must bill the vaccine procedure code with the *SL* modifier. The provider will be reimbursed at the lesser of provider charge or the rate found in the *State Max* column of the Practitioner Fee Schedule.
- Providers should still verify Title eligibility because the VFC program requires different stock to be used (DPH policy); however, Title eligibility will not be used to determine reimbursement.

- Vaccines not available through VFC (example: rabies vaccine) are reimbursed at the lesser of provider charge or the rate found in the State Max column of the Practitioner Fee Schedule.
- Vaccinations can be administered during a sick visit when medically appropriate.
 Reimbursement will follow guidelines above.

iii. Newborns

For newborns who are added to Medicaid less than 46 days from the date of birth:

- Their eligibility date and birth date will be the same
- If mom is enrolled with the MCO on the newborn's date of birth, the newborn will be assigned to the same MCO and their eligibility will be *retroactive* to newborn's date of birth.
- Services are to be billed to the MCO

For newborns who are added to Medicaid between 46 days and 364 days from date of birth:

- Mom is currently assigned to an MCO
- Infant will be assigned to the Mom's MCO
- Services provided from newborn's date of birth until begin date of MCO eligibility should be billed to HFS as fee-for-service
- Services provided from begin date of MCO eligibility forward can be billed to the MCO

Billing Newborn Services:

Pediatricians providing services to a newborn who does not yet have a RIN should submit the claim to the mother's MCO under the mother's RIN. Providers should not hold claims until a RIN is received to avoid running into timely filing requirements. Claims submitted under the mother's RIN will deny; however, providers can use their denied claims to track newborns awaiting RINs and then submit a corrected claim once the newborn RIN is assigned.

E. Billing Scenarios

Assumptions:

The following are common scenarios that often present billing issues for pediatricians. This guidance is intended to clarify correct claim submission requirements for successful adjudication and payment.

For all scenarios, it is assumed:

- Member is active and provider is in-network on the day(s) of service;
- NPI is registered and active in IMPACT for dates of service;
- Any authorizations for service(s) are completed and included on claim, as applicable;
- Appropriate taxonomy code is present based on service type (click here for a listing of taxonomy codes). The taxonomy code used on the scenarios is for demonstration purposes only and is not the only acceptable code for more information, see the Manual Introduction, Section II-C;
- Physician is credentialed and active;
- Physician is enrolled in the Vaccines for Children (VFC) program;
- Member is empaneled to the primary care provider providing service (as applicable based on plan);

- Member eligibility for Title 19, Title 21, or SF has been validated by staff on date of service; it is recommended, but not required, that provider keep a screen shot of this validation;
- Patient is assigned an accurate plan number;
- Claim form is accurate for the provider setting (the CMS1500 is used here for demonstration purposes, but corresponding EDI loops are also acceptable;
- Patient demographics (e.g., sex, age, etc.) are accurate for the services billed (do not conflict with any additional coding edits specific to these elements);
- "From," "Through," and "Admission" (if applicable) dates are accurate;
- Bill type used is accurate for services rendered; and
- MCOs generally follow all National Correct Coding Initiative (NCCI) guidelines.

Scenario 1: Well-Child Visit - Newborn:

Baby is seen for 3 to 7 days for new newborn well visit. Newborn has no coverage listed in MEDI. Child is in need of general history and exam, vitals, weight, height, and head circumference. Also, infant needs referral for jaundice test, cardiologist and referral for screening for hip dysplasia at 4-6 weeks old.

Billing Code:

99381

Billing Requirements for Scenario 1

For newborns who are added to Medicaid less than 46 days from the date of birth:

- Their eligibility begin date and birth date will be the same
- If mom is enrolled with the MCO on the newborn's date of birth, the newborn will be assigned to the same MCO and their eligibility will be *retroactive* to newborn's date of birth.
- Services are to be billed to the MCO

For newborns who are added to Medicaid between 46 days and 364 days from date of birth:

- Mom is currently assigned to an MCO
- Infant will be assigned to the Mom's MCO
- Services provided from newborn's date of birth until begin date of eligibility should be billed to HFS as fee-for-service
- Services provided from begin date of MCO eligibility forward can be billed to the MCO

Billing Newborn Services:

Pediatricians providing services to a newborn who does not yet have a RIN should submit the claim to the mother's MCO under the mother's RIN. Providers should not hold claims until a RIN is received to avoid running into timely filing requirements. Claims submitted under the mother's RIN will deny; however, providers can use their denied claims to track newborns awaiting RINs and then submit a corrected claim once the newborn RIN is assigned.

Scenario 2: Well-Child Visit 0-2 Months old, 4 Months old & 6 Months old

Baby is seen at age 2, 4 and 6 months for well child visit. Baby is listed as covered under accepted MCO and as Title 21 for vaccines. Suspicion of developmental delay. Services including history and exam, weight, height, head circumference, vitals, developmental screening, post-partum depression screen, and vaccines.

Billing Codes:

99391 preventive medicine under age 1
96110 developmental screen
96127 HD post-partum depression screening

Vaccine Codes:

90723 DTaP-HepB-IPV 90670 Prevnar (pneumococcal 13) 90647 Hib PRP-OMP (Hemophilus Influenza)

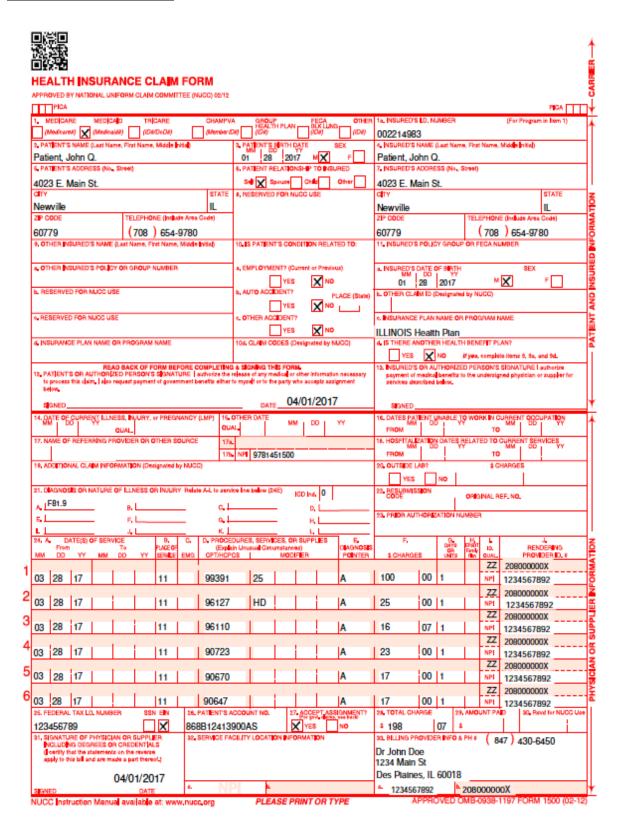
90680 Rotavirus

Billing Requirements for Scenario 2

- 1) The claim would need to be submitted to the appropriate payer (MCO) under the child's Medicaid ID once enrolled. Newborn enrollment is the responsibility of HFS and not the MCO. See Scenario 1 for more guidance.
- 2) Post-partum depression screening (Edinburgh Maternal depression screening) must be billed with 96127 with the HD modifier (96161 is used for commercial plans only see Commercial/Medicaid coding grid)
- 3) For vaccination billing guidance please refer to vaccination section.

See Sample Claim on following page (showing billing for vaccinations occurring PRIOR to 8/31/19.

Scenario 2: Sample Claim



Scenario 3: Well Child Visit - 9 months old:

Baby is seen at age 9 months for Well Child care. Services include History/Exam, weight, height, head circumference, developmental screen, and vaccines including flu. Child is listed as covered by MCO and Title 21 eligible and is also enrolled in WIC.

Billing codes:

99391 preventive medicine under age 196110 developmental screen85018 Hemoglobin83655 Lead screening36416 collection capillary blood specimen

Vaccines:

90686 Influenza, no preservative quadrivalent

They will have to return in one month for second flu vaccine.

Billing Requirements for Scenario 3

For vaccination billing, please refer to vaccination billing section above See sample claim Scenario 3 on following page, showing billing for services PRIOR to 8/31/19 (for vaccination purposes)

Scenario 3: Sample Claim

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Scenario 4: Well Child Visit - 12 months old:

Baby is seen at age 12 months for Well Child care. Services include History/Exam, weight, height, head circumference, developmental screen, vaccines, lead test, hemoglobin, and fluoride varnish.

Billing Codes:

99392 preventive medicine 96110 developmental screen 85018 Hemoglobin 83655 Lead screening 36416 collection capillary blood specimen

Vaccines:

90686 Influenza, no preservative quadrivalent 90707 MMR (Measles Mumps Rubella) 90716 Varivax (Varicella) 90633 Hep A D1206 Fluoride Varnish

Billing Requirements for Scenario 4:

- Procedure 36416 (part of lead screening) is only payable with a U1 modifier.
- Procedure 85018 should have a QW modifier.

For vaccination billing, please refer to vaccination section above.

See sample claim on the following page(s).

Scenario 4: Sample Claim (Page 1 of 2)

HEALTH INSURANCE CLAIM FORM								
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12								
PIEA			PICA TO					
1. MEDICARE MEDICAID TRICARE CHAMPY (Medicard) X (Medicard) (DEO-OH) (Member)	— HEALTH PLAN — BUX LUNG —		(For Program in Bem 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	002214983 4. INSURED'S NAME (Last Name, First Na	xme, Middle Britisl)						
Johnson, Michaela	Johnson, Michaela							
S, PATIENT'S ADDRESS (No., Street)	7. INSURED'S ADDRESS (No., Street)							
4023 E. Main St.	8-8 X Specie Child Other 8. RESERVED FOR NUCG USE	4023 E. Main St.						
Newville IL		Newville	IL HONE (Jadjude Area Gode) 708) 654-9780					
ZIP CODE TELEPHONE (Individe Area Code)		ZIP GODE TELEPI	HONE (Include Area Code)					
60779 (708) 654-9780 s. OTHER INSURED'S NAME (Last Name, First Name, Middle British)	10. IIS PATIENT'S CONDITION RELATED TO:	60779 (7 11. INSURED'S POLICY GROUP OR FEC	708) 654-9780					
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4, INSURANCE PLAN NAME OR PROGRAM NAME	10d, CLAIM CODES (Designated by NUCC)	ILLINOIS Health Plan 4.8 THERE ANOTHER HEALTH BENEF	T PLAN?					
		YES NO If yes, complete forms 9, 5s, and 3d,						
READ BACK OF FORM BEFORE COMPLETING A SIGNING THIS FORM. 12. PATENT'S OR AUTHORIZED PERSON'S SIGNATURE: I substitute the release of any medical or other information necessary to process this diam. I also request payment of government benefits either to myself or to the party who accepts assignment services described below.								
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18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	,	20, OUTSIDE LAB?	\$ CHARGES					
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NCLUDING DEGREES OR CREDENTIALS () certify that the statements on the reverse apply to this bill and are made a part thereoC)	CRITY LOCATION INFORMATION	Dr. John Doe 1234 Main Street Des Plaines, IL 60018	847) 430-8450					
04/01/2019 SIGNED DATE N		3000000X						
NUCC Instruction Manual available at: www.nucc.org		38-1197 FORM 1500 (02-12)						

Scenario 4: Sample Claim (Page 2 of 2)

HEALTH INSURANCE CLAIM FORM					
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12					
PIEA			PICA		
1. MEDICARE MEDICAID TRICARE CHAMPY	- HEALTH PLAN - BUCLLING -		(For Program in Bern 1)		
(Medicare#) (Medicald#) (DWO+D#) (Member li	A) ((DA) ((DA) ((DA)	002214983			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name	, First Name, Middle Initial)		
Johnson, Michaela	01 24 2018 M F X	Johnson, Michaela			
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., S	tree()		
4023 E. Main St.	Self X Spouse Child Other	4023 E. Main St.			
CITY STATE	8. RESERVED FOR NUCC USE	CITY	STATE		
Newville IL		Newville	IL		
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)		
60779 (708) 654-9780		60779	(708) 654-9780		
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Scenario 5: Well-Child and School Physical 16-years old

Child seen for Well Child care. Child is overweight and needs school physical form completed. Services include history/exam, weight, height, blood pressure, vitals, hemoglobin, TB skin test, BMI screening, depression screening and adolescent vaccines. Also needs screening for CBC, fasting lipids and fasting glucose.

Child is listed as Title 21 eligible.
PHQ9- Adolescent Depression questionnaire, vaccines

Billing Codes:

99394 preventive medicine 96127 PHQ9 Depression Questionnaire 36415-venous blood draw 86580-PPD (TB skin test)

Vaccines:

90649 HPV 90734 MCV4 90686 Flu (T19) 90688 Flu T 21 90620 (or 90621) MenB

Billing Requirements for Scenario 5

- For vaccination billing, please refer to vaccination section above.
- PHQ-9 screenings are to be billed with code 96127. Code 96160 is for commercial billing only.
 Drug and Alcohol Screenings also are to be billed with Code 96127. When both tests are performed at the same visits, use Code 96127, with 2 units of service. (See commercial/Medicaid coding grid)

HPV Vaccines have 2 different codes:

- CPT code 90649 (Gardasil)
- CPT code 90650 (Cervarix)

If the vaccine is given as part of a preventive health care service, such as a well-child visit, ICD-10 requires only one diagnosis code (Z023) per vaccination, regardless if single or combination. Report Z23 for all vaccination diagnoses.

Dosing:

- The quadrivalent HPV4 vaccine and bivalent HPV2 vaccine are each administered in a 3-dose schedule, with the second dose administered 1 to 2 months after the first dose and the third dose 6 months after the first dose.
- The minimum interval between the first and second doses of vaccine is 4 weeks. The minimum interval between the second and third dose of vaccine is 12 weeks. The minimum interval between the first and third dose is 5 months.

Billing:

- Bill the appropriate minimal level office visit or other outpatient visit for evaluation and management and bill the specific vaccine procedure codes.
- For vaccination billing, please refer to vaccination billing section above.

Billing Example:

Vaccine	СРТ	Modifier	Office Visit	Schedule
HPV4 (Gardasil)	90649	25	99XXX	3 Doses
HPV2 (Cervarix)	90650	25	99XXX	3 Doses

See sample claim on the following page(s).

Scenario 5: Sample Claim (Page 1 of 2)

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Scenario 5: Sample Claim (Page 2 of 2)

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XIII. CBS (Community Based Behavioral Services)

A. Purpose

MCOs have implemented updated standard claims submission processes to be utilized for the reimbursement of services rendered by certified and enrolled Community Mental Health Centers (CMHCs) and Behavioral Health Clinics (BHCs) as required by the Illinois Department of Healthcare and Family Services (HFS). CMHCs eligible to render covered services must adhere to the following prescribed billing criteria to be reimbursed correctly by MCO.

Services Overview -Rule 132 -Prior to 8/1/2018

HFS contracted Managed Care Plans are required to provide coverage for mental health services covered under the HFS Medical Assistance Program, as detailed in the Service Definition and Reimbursement Guide (SDRG), or its successor Provider Handbook. The SDRG can be found here.

Definitions

The following common terms are used throughout this billing guide.

- 1. Clinician refers to the qualified individual within a CMHC site delivering a covered service.
- 2. MHP refers to an individual who meets the definition for a Mental Health Professional as described in 59 III. Administrative Code 132.25.
- 3. Provider refers to a uniquely certified CMHC site, operating under a distinct National Provider Identification (NPI) number.
- 4. QMHP refers to an individual who meets the definition for a Qualified Mental Health Professional as described in 59 III. Administrative Code 132.25.
- 5. Rolled Up is a term used to describe how a provider may bill for numerous incidents of the same service provision during a day, done by totaling the number of separate units of the service provided onto one service line on a claim for the purposes of billing. Please see the Billing Examples section for additional details.
- 6. RSA refers to an individual who meets the definition for a Rehabilitative Services Associate as described in 59 III. Administrative Code 132.25.
- 7. Same Service refers to a specific service delivered at a specific level of care and at a specific location, represented on a claim by a distinct procedure code, modifier, and place of service combination.

Services Overview- Rule 140- After 8/1/2018

The Community-Based Behavioral Services **CBS** Provider Handbook replaces the Community Mental Health Service Definition and Reimbursement Guide (SDRG) effective immediately. Title 59 IAC 132 (Rule 132) and Title 89 IAC 140 (Part 140) apply to different service functions in the Illinois Administrative Code. Part 140 does not replace Rule 132.

Title 59 IAC 132, or "Rule 132," establishes the requirements an entity must meet in order to be certified as a Community Mental Health Center (CMHC). Any and all service references or requirements in Rule 132 pertain specifically to state-funded services purchased by Department of

Human Services/Division of Mental Health (DHS-DMH) using state-only funds and does not govern services under Illinois Medical Assistance Program that may be eligible for federal financial participation.

Title 89 IAC 140 or "Part 140" establishes the broad range of requirements all providers must meet to be eligible for reimbursement under the Illinois Medical Assistance Program. It also provides for a new provider type Behavioral Health Clinics (BHCs) and integrates Medicaid Rehabilitation Option – Mental Health (MRO-MH) services into the Part 140 structure. By placing MRO-MH services into the Part 140 structure, HFS standardized the definition of mental health services across multiple provider types while reducing the overall administrative burdens placed upon providers.

B. Provider Type and Taxonomy Codes

This section applies to providers who are registered with HFS as provider type 036- Community Mental Health Center (Tables 1, 3A and 4), provider type 027- Behavioral Health Clinic (Table 1, 3B) and certain independent practitioners (IPs) as indicated in Table 2:

Table 1. CMHC and BHC Defined for Group A Services in HFS CBS Handbook						
Provider	Designation	HFS Provider Type	HFS Taxonomy			
Community Mental Health Center	Facility, Agency, Organization	036	261QM0801X			
Behavioral Health Clinic	Facility, Agency, Organization	027	Children and adolescents 261QM0855X Adult – Taxonomy 261QM0850X			

Table 2. Independent Practitioners (IPs) Defined for Group A Services in HFS CBS Handbook *This type of practitioner does NOT apply to Rule 132 or 140						
Provider	Designation	HFS Provider Type	HFS Taxonomy			
Licensed Clinical Psychologist	LCP	087	103T00000X			
Licensed Clinical Social Worker	LCSW	086	1041C0700X			
Other Behavior Health including Licensed Clinical Professional Counselor (LCPC) and Licensed Family and Marriage Therapist (LFMT)*	Any provider who is registered as provider type 88 with HFS	088	101Y00000X			
Psychiatrist (Physician)	MD	010	207Q00000X			

*LCPC and LFMT effective 10/1/2021

Table 3A. CMHC and BHC Defined for Group B in HFS CBS Handbook						
Provider	Designation	HFS Provider Type	HFS Specialties	HFS Taxonomy		
Community Mental Health Center	Facility, Agency, Organization	036	Certain procedure codes in GROUP B require the provider to be designated in IMPACT with specialties of: • 'Crisis Stabilization', • 'Mobile Crisis Response', • 'Community Support Team', • Intensive Outpatient'	261QM0801X		

Table 3B. CMHC and BHC Defined for Group B Services in HFS CBS Handbook							
Provider	Designation	HFS Provider Type	HFS Specialties	HFS Taxonomy			
	Certain procedure codes in GROUP B require the provider to be designated in IMPACT with specialties of: • Crisis Stabilization	Children and adolescents 261QM0855X					
	Ü		Mobile Crisis ResponseIntensive Outpatient'	Adult 261QM0850X			

Table 4. CMHC Defined for Group C Services in HFS CBS Handbook						
Provider	Designation	HFS Provider Type	HFS Specialties	HFS Taxonomy		
Community Mental Health Center	Facility, Agency, Organization	036	Certain procedure codes in GROUP C require the provider to be designated in IMPACT with specialties of: • Assertive Community Treatment • Psychosocial Rehabilitation	261QM0801X		

NPIs

CMHC providers are required to register their NPIs as a Provider Type 036- Community Mental Health Center with IMPACT. BHC providers are required to register their NPIs as a Provider Type 027-Behavioral Health Clinic with IMPACT. IPs are expected to be registered in IMPACT with the appropriate details as indicated in Table 2 above.

BHC (provider type 027) and CMHC (provider type 036) services may only be rendered from a site that is certified by the Illinois Department of Human Services / Division of Mental Health (DHS-DMH). The NPI the provider uses to bill MCO Plans must correspond to a CMHC or BHC certified site.

Providers offering both substance abuse services and mental health services from the same site may not utilize the same NPI number for billing substance abuse and mental health services. Mental health services must be billed using a different NPI number from the substance abuse services.

IMPORTANT NOTE: Always ensure the NPI on the claim matches the IMPACT Medicaid IDs on record. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, specialties etc.

Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to a MCO, the specialties and subspecialties registered in the HFS Provider IMPACT system are critical to accurate claims payment. If a provider does not have the appropriate specialty or subspecialties registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the **Provider Information Sheet** provided by HFS.

C. Coding and Billing Guidelines

Coding Requirements

General Claims Submission Requirements:

- 1. To be reimbursed for services provided to a recipient who receives a HFS Medical Assistance Program benefit and who is enrolled with a HFS contracted Managed Care Plan, CMHCs must be fully contracted and credentialed with that Managed Care Plan on the date of service.
- 2. CMHC services may only be rendered from a certified site. The NPI number providers use to bill Managed Care Plans must correspond to a certified CMHC site.
- 3. Providers rendering both substance abuse and mental health services from the same site shall not utilize the same NPI number for billing substance abuse and mental health services. Mental health services must be billed under a separate NPI number from substance abuse services. Providers that do not obtain and report a unique NPI for each provider type may be subject to claims denial.
- 4. Providers with multiple certified sites must obtain a unique NPI number for each CMHC site.
- 5. Providers that do not obtain and report a unique NPI for each provider site may be subject to claims denial.
- 6. It is the responsibility of the provider to ensure compliance with all the service requirements of a recipient's payer, including service notifications or prior authorizations. Prior to providing CMHC services, providers should reference the MCO Provider Agreements for information on service requirements. A crosswalk of the prior authorization requirements of each of the HFS contracted Managed Care Plans can be found in Coding Requirements. Providers that do not comply with the service requirements of a recipient's payer may be subject to claims denial.

All outpatient CBS services for Group A, Group B and Group C for approved provider types (Table 1-4) are to be submitted on an 837P claim with the appropriate procedure codes and appropriate modifiers.

As per the Medicaid Reimbursement webpage for Community Mental Health Providers, the following procedure codes are to be used for billing services in Group A, Group B and Group C:

Service Name	HCPC Code		Modifiers			
Service realine	ner e coue	1	2	Units		
Group A - billable by BHC and CMHC and IPs	s See Table 1 a	nd Table 2 for prov	vider eligibility			
Integrated Assessment and Treatment Planning (IATP)	H2000	HN		1/4 hr		
Integrated Assessment and Treatment Planning (IATP)	H2000	НО		1/4 hr		
IATP: Psychological Assessment	H2000	АН		1/4 hr		
IATP: Psychological Assessment	H2000	НР		1/4 hr		
IATP: LOCUS Assessment	H2000	HN	HE	1/4 hr		
IATP: Clinical Assessment Tool under LPHA direction Effective with DOS beginning 7/1/22	H2000	52		1/4 hr		
IATP: Clinical Assessment Tool performed by an LPHA	H2000	TF		1/4 hr		
IATP: LPHA Review Effective with DOS beginning 7/1/22	H2000	SC		1/4 hr		
IATP: Review and Update	H2000	HN	SF	1/4 hr		
IATP: Review and Update	H2000	НО	SF	1/4 hr		
Crisis Services						
Crisis Intervention	H2011	HN		1/4 hr		
Therapy/Counseling Services			1			
Therapy/Counseling - Individual	H0004	HN		1/4 hr		
Therapy/Counseling - Individual	H0004	НО		1/4 hr		
Therapy/Counseling – Brief Intervention (eff. 10/1/2021)	H0004	TF	TL	1/4 hr		
Therapy/Counseling - Group	H0004	HN	HQ	1/4 hr		
Therapy/Counseling - Group	H0004	НО	HQ	1/4 hr		
Therapy/Counseling - Family	H0004	HN	HR	1/4 hr		
Therapy/Counseling - Family	H0004	НО	HR	1/4 hr		
Group B - billable by BHC and CM	IHC- See Table 3	for provider eligib	ility			
General Medicaid Rehabilitation Option Services						
Community Support - Individual	H2015	НМ		1/4 hr		
Community Support - Individual	H2015	HN		1/4 hr		
Community Support - Individual	H2015	НО		1/4 hr		
Community Support – Individual (BHC providers are not eligible to bill this code with the HK modifier) Effective with dates of service on and after 7/1/22, services provided in a residential setting are no longer required to use the HK modifier)	H2015	HN	нк	1/4 hr		
Community Support - Group	H2015	НМ	HQ	1/4 hr		
Community Support - Group	H2015	HN	HQ	1/4 hr		
Community Support - Group	H2015	НО	HQ	1/4 hr		
Medication Administration**	T1502	TE		Event		
Medication Administration**	T1502	SA		Event		
Medication Monitoring	H2010	52		1/4 hr		
Medication Monitoring	H2010	SA		1/4 hr		
Medication Monitoring	H2010	AF		1/4 hr		
Medication Training - Individual	H0034	52		1/4 hr		
Medication Training - Individual	H0034	SA		1/4 hr		

Service Name	HCPC Code	Mod	Units		
			2	Offics	
Medication Training - Group	H0034	52	HQ	1/4 hr	
Medication Training - Group	H0034	SA	HQ	1/4 hr	
Targeted Case Management Services					
Case Management - Client-Centered Consultation	T1016	НМ	HS	1/4 hr	
Case Management - Client-Centered Consultation	T1016	HN	HS	1/4 hr	
Case Management - Mental Health	T1016	НМ		1/4 hr	
Case Management - Mental Health	T1016	HN		1/4 hr	
Case Management - Transition Linkage and Aftercare	T1016	HN	TS	1/4 hr	
Case Management - Transition Linkage and Aftercare	T1016	НО	TS	1/4 hr	
Crisis Services		<u>'</u>			
Crisis Intervention – Team**	H2011	HN	HT	1/4 hr	
Crisis Stabilization** Effective with DOS beginning 7/1/22, unit is 1/4 hr increment, not 1 hr.	T1019	HN		1 hr	
Mobile Crisis Response**	S9484	HN		Event	
Mobile Crisis Response – Team**	S9484	HN	HT	Event	
Intensive Services Requiring Program Certification					
Community Support Team (CST)*	H2016			1/4 hr	
Mental Health Intensive Outpatient - Adult Program**	S9480	НО	НВ	1 hr	
Mental Health Intensive Outpatient - Child Program**	S9480	НО	HA	1 hr	
Violence Prevention Community Support Team (VP-CST) – Individual Effective with Dates of Service beginning 5/1/2022 – see 4/15/22 HFS Notice	H0037	Modifier corresponding to staff level		1/4 hr	
Violence Prevention Community Support Team (VP-CST) – Group Effective with Dates of Service beginning 5/1/2022 - see 4/15/22 HFS Notice	H0037	HQ	Modifier corresponding to staff level	1/4 hr	
Behavioral Health Screening Services					
Developmental Screening**	96110	TF		Event	
Developmental Testing**	96111	TF		Event	
Mental Health Risk Assessment**	96127	TF		Event	
Prenatal Care At-Risk Assessment**	H1000	TF		Event	
Family Support Program (FSP) Services					
FSP Application Assistance	G9012	HN	SE	1/4 hr	
FSP Clinical Case Participation	T1016	HN	SE	1/4 hr	
FSP Family Support Services	T1999	SE		Event	
FSP Therapeutic Support Services	H0046	SE		Event	
Group C - billable by CMHC onl			v	230.70	
Telehealth Services	, see rable 4 le	or provider engionic			
Telepsychiatry: Originating Site**	Q3014	HN		Event	
Intensive Services Requiring Program Certification	Q0027			270110	
Assertive Community Treatment (ACT) - Individual*	H0039			1/4 hr	
Assertive Community Treatment (ACT) - Group*	H0039	HQ		1/4 hr	
Psychosocial Rehabilitation – Individual**	H2017	НМ		1/4 hr	
. 57 S. SSSSIAI NEIGAMILLAGIII III III III III III III III III II					
Psychosocial Rehabilitation – Individual**	H2017	HN		1//Lhr	
Psychosocial Rehabilitation – Individual** Psychosocial Rehabilitation – Individual**	H2017 H2017	HN		1/4 hr 1/4 hr	

Service Name	HCPC Code	Mod	Units	
		1	2	Omes
Psychosocial Rehabilitation – Group**	H2017	HN	HQ	1/4 hr
Psychosocial Rehabilitation – Group**	H2017	НО	HQ	1/4 hr

^{*}Assertive and Community Treatment (ACT) and (Community Support Team) CST services must be billed with an additional modifier indicating the highest level of practitioner level delivering the unit(s) of service from the acceptable list of modifiers. See the HFS Community Behavioral Services Handbook for more information.

Modifiers:

For additional clarity, the following is the modifier key according to the HFS CBS Handbook:

	Modifier Key
Modifier	Description
52	Lower level of care
AF	Physician
AH	Psychologist Masters
ET	Crisis Service
GT	Telehealth Services (Audio and Video) – SEE NOTES NOTE: Effective with dates of service of 10/1/2021, providers billing a service that was performed via audio or video communication must use the procedure code with modifier GT and Place of Service code 02. See the Handbook for Providers of Community-Based Behavioral Services for more information. NOTE: Effective with dates of services 7/1/2022, the GT modifier is only to be used for telehealth services using both audio AND video communication. POS code is still required and should match the distant site location.
93	Telehealth Services (Audio ONLY) Effective with dates of services 7/1/2022, the Modifier 93 is to be used to indicate telehealth services using audio communication only. POS code is still required and should match the distant site location.
Н9	Forensic Service
НА	Child Program
НВ	Adult Program
HE	LOCUS assessment
НН	Substance Use Disorder (SUD) worker
HJ	Employment Supports
HK	High-risk mental health program
НМ	RSA
HN	MHP
НО	QMHP
HP	Psychologist - Licensed Clinical
HQ	Group setting
HR	Family/couple
HS	Client not present
HT	Multidisciplinary team
HW	Funded by DMH
SA	APN
SE	FSP service
SF	Review
TD	RN
TE	LPN/LVN
TF	LPHA
TG	Complex level of care
TS	Transition Service

^{**}These services are NOT permitted to be delivered via telehealth. See the HFS Community Behavioral Health Handbook – Section 208 for further information.

Allowable Place of Service Codes

	Allowable Place of Service Codes
On-Site	Off-Site
02 – Telehealth (see GT modifier note on previous page)	03 - School
10 – Telehealth rendered to a member who is located in their <i>home</i> (effective with dates of services starting 7/1/2022)	04 - Homeless Shelter
11 - Office	12 - Home
15 - Mobile Unit	13 - Assisted Living Facility
20 - Urgent Care Facility	14 - Group Home
53 - Community Mental Health Center	21-Inpatient Hospital- (Hospital)
·	22 - On-Campus Outpatient Hospital
	23 - Emergency Room - Hospital
	26 - Military Treatment Facility
	31- Skilled Nursing Facility (SNF)
	32 - Nursing Facility
	33 - Custodial Care Facility
	34 - Hospice
	51-Inpatient Psych Facility (Free Standing Psych)
	52 - Psychiatric Facility - Partial Hospitalization
	54-Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)
	55-Substance Use Disorder (SUD) Residential
	56- Psychiatric Residential Treatment Facility (PRTF)
	57- Substance Use Disorder (SUD) Treatment Site
	71 - Public Health Clinic
	99 - Other Place of Service

Rendering and Billing Provider:

Billing Provider

Billing Provider represents the payee on an individual claim. The NPI corresponding to the payee ID where a provider wants remittance advice and payments sent should be reported in loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form. If the billing NPI also corresponds to the rendering provider site, no rendering provider NPI is required on the claim.

Rendering Provider

Rendering Provider represents the specific CMHC site that delivered the services on the claim. For CMHCs, Rendering Provider can be captured at the entity level, not the individual clinician level. The NPI for the Rendering Provider must be reported if the Billing Provider NPI corresponds only to a payee ID or to a different provider site location. HFS advises that the rendering provider must have the payee ID associated to the Billing Provider NPI at HFS. The Rendering Provider is reported in loop 2310B on 837P submissions or Box 24J on a CMS 1500 form.

CMHC as the Payee:

It is allowable for qualified practitioners (i.e., physicians, psychiatric advanced practice nurses) to deliver psychiatric services in a CMHC and list the CMHC as the Billing Provider (loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form) on the claim. For these claims to adjudicate appropriately as a practitioner service rather than a CMHC service, the claim must list the NPI for the practitioner

delivering services in the Rendering Provider field (loop 2310B on 837P submissions or Box 24J on a CMS 1500 form) and report an allowable procedure code from the appropriate **practitioner fee schedule**. The Rendering Provider must comply with MCO's policies, procedures, and service requirements corresponding to the practitioner's provider type, including being enrolled as an active provider with HFS and MCO on the date of service.

Duplicate Claiming

CMHCs may provide multiple units of the same service to the same recipient on the same day. MCO claiming systems shall be set up to recognize each distinct procedure code, modifier, and place of service combination covered under the HFS Medical Assistance Programs as a unique service. Effective 6/1/2017, if multiple CMHC services are rendered to the same Member on the same day at the same or different site, the claims can be billed on same or separate claim and WILL NOT reject as duplicate. **Please review the billing examples below.**

Billing Guidelines and Examples:

Providers may only be reimbursed once for delivering multiple units of the same procedure/modifier and place of service combination to one recipient on the same day. These services must be "rolled up" onto one service line on a single claim to avoid a rejection for a duplicate claim.

Example 1: An MHP-level staff at a CMHC provides a total of two units of Case Management – Mental Health in the office to a single recipient, but at separate times of the day (not back to back). The service (same code/modifier/place of service combination), the provider NPI, the recipient, the date of service, and place of service all remain the same. The provider correctly bills Case Management – Mental Health on one service line using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	T1016	HN	11	2

Example 2: An MHP-level staff at a CMHC provides two units of Crisis Intervention in the office to a single recipient. Later that same day, the same recipient returns to the same CMHC and a different MHP-level staff provides two additional units of Crisis Intervention to the recipient. The CMHC provider bills Crisis Intervention on two service lines on a single claim using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011	HN	11	2
1	H2011	HN	11	2

This claim has not been billed appropriately. Service Line 1 will positively adjudicate, but Service Line 2 will be denied as a duplicate claim. For CMHC services, the provider is identified at the entity level, not the clinician level. Therefore, because the recipient, the service (procedure code/modifier/place of service combination), the provider NPI, and the date of service all remained the same, the provider should <u>roll up</u> the services and bill Crisis Intervention on one service line using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011	HN	11	4

Example 3: An MHP-level staff at a CMHC provides three units of Integrated Assessment and Treatment Planning (IATP) in the office to a single recipient. A QMHP-level staff at the same CMHC provides an additional unit of IATP, also in the office, to the same recipient on the same day. The provider correctly bills IATP on two separate services lines using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2000	HN	11	3
1	H2000	НО	11	1

The provider correctly separated the services provided onto two distinct service lines using the appropriate modifiers to account for the change in the clinician qualification level.

Example 4: An MHP-level staff at a CMHC provides two units of Crisis Intervention in the office to a single recipient. Later that same day, the same MHP-level staff provides two more units of Crisis Intervention to the same recipient, but this time at the recipient's home. The provider correctly bills Crisis Intervention on two separate service lines using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011		11	2
1	H2011		12	2

The provider correctly separated the services provided onto two distinct service lines using the appropriate Place of Service codes to account for the change in location.

Providers delivering the same service to the same client, but from two different places of services, under a single CMHC's NPI, on the same day must submit the services on two different service lines, using the appropriate place of service codes to distinguish the two services from one another.

Example 5: An RSA-level staff at a CMHC provides two units of Community Support Individual to a single recipient at the recipient's employer. Later that same day, an RSA-level staff provides three more units of Community Support Individual to the same recipient, but this time at a local community center. The provider bills Community Support Individual on two separate service lines using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2015	НМ	99	2
1	H2015	НМ	99	3

This claim has not been billed appropriately. Service Line 1 will positively adjudicate, but Service Line 2 will be denied as a duplicate claim. Although the physical location for which services were delivered changed from an employer setting to a community center, the place of service code did not change. Consistent with the Community-Based Behavioral Services CBS Provider Handbook, there is no place of service for employer or community center as a result 99 is the appropriate place of service code. Because the recipient, the service (procedure code/modifier/place of service combination), the provider's NPI, and the date of service all remained the same, the provider should roll up the services and bill Community Support Individual on one service line using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2015	НМ	99	5

1115 Waiver Initiatives

Illinois has outlined an ambitions strategy to improve behavioral health outcomes working with CMS for 'waiver' of federal Medicaid requirements so State government can pilot or demonstrate projects. The purpose of these demonstrations is to evaluate policy approaches such as providing services not typically covered by Medicaid or creating innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Examples of State Plan Amendments (SPAs) or pilots that have been pursued by the state are:

- Crisis Stabilization (per the Medicaid Reimbursement webpage for Community Mental Health Providers) Effective 8/1/2018
- Crisis Intervention Services- Mobile Crisis Response (per the Medicaid Reimbursement webpage for Community Mental Health Providers) Effective 8/1/2018
- Effective 10/1/2018, Intensive-In Home Service Pilot- Effective 10/1/2018
- Residential/Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot- Effective 1/1/2019 which increased the members eligible for this program as well as facilities that qualify as an Institution from Mental Diseases (IMD). (see Substance Use Prevention & Recovery (SUPR) Billing Guidance)
- Clinically Managed Residential Withdrawal Management for individuals with Substance Use Disorder (SUD) Pilot – Effective 2/1/2019 the state will cover clinically managed withdrawal management services. (see SUPR Billing Guidance)
- SUD Case Management Pilot Effective 2/1/2019 the state will cover SUD case management services that assist the member to access needed medical, social, educational, and other services. (see SUPR Billing Guidance)
- Peer Recovery Support Services Pilot Effective 2/1/2019 this state will cover peer recovery support services delivered by individuals in recovery from a substance use disorder (peer recovery coach) who is supervised to provider counseling support to help prevent relapse and promote recovery. (see SUPR Billing Guidance)

HFS provides MCOs with a weekly file (referred to as the 'Weekly OBRA File') that contains the list of approved members who are eligible for the following pilots:

 Clinically Managed Residential Withdrawal Management for individuals with Substance Use Disorder (SUD) (see SUPR Billing Guidance)

- SUD Case Management Pilot (see SUPR Billing Guidance)
- Peer Recovery Support Services Pilot (see SUPR Billing Guidance)
- Intensive In-Home Service Pilot- see below. **NOTE: This Pilot is in place form 10/1/208 to** 6/30/2023. It will be replaced with Intensive Home-Based Services under the Pathways to Success Program. Refer to the Pathways to Success section for details.

Intensive In-Home Service Pilot

Provider Type and Taxonomy Codes

This section applies to providers who are registered with HFS as provider type 036 - Community Mental Health Center, or provider type 027- Behavioral Health Clinic beginning **10/1/2018 until 6/30/2023**.

CMHC and BHC Intensive In-Home Service Pilot							
Provider	Designation	HFS Provider Type	HFS Taxonomy				
Community Mental Health Center	Facility, Agency, Organization	036	261QM0801X				
Behavioral Health Clinic	avioral Health Clinic Facility, Agency, Organization		Children and adolescents 261QM0855X				

The following are the applicable procedure codes, modifiers, applicable places of service, form type and member requirements:

Service Name	HCPC Code	Mod	ifiers	Units	Place of Service Rules	Form Type	Approval for member to participate from HFS
		1	2				required
Intensive In-Home - Clinical Only	H2020	TG	TG	Event	04 – Homeless Shelter	837P	OBRA Code = RI
Intensive In-Home - Support Only	H2020	SC	SC	Event	12- Home 13 - Assisted Living	837P	OBRA Code = RI
Intensive In-Home - Both Clinical and Support	H2020	TG	SC	Event	Facility 14- Group Home	837P	OBRA Code = RI

Table 1. Intensive In-Home Payment and Claiming Cycle

Service Week	Week Begin	Week End	Date of Service on Claim	Adjusted Payment Measures	
Engagement Week	Day 1	Day 7	Day 7		
Initial - Week 1	Day 8	Day 14	Day 14	Adjustment Period 1:	
Initial - Week 2	Day 15	Day 21	Day 21	No inpatient psychiatric services Remain enrolled in IHH (as	
Initial - Week 3	Day 22	Day 28	Day 28	applicable)	
Initial - Week 4	Day 29	Day 35	Day 35		
Initial - Week 5	Day 36	Day 42	Day 42	Adjustment Period 2:	
Initial - Week 6	Day 43	Day 49	Day 49	No inpatient psychiatric services	
Initial - Week 7	Day 50	Day 56	Day 56	Remain enrolled in IHH (as	
Initial - Week 8	Day 57	Day 63	Day 63	applicable)	
Extension 1 - Week 1	Day 64	Day 70	Day 70	Adjustment Period 3: No inpatient psychiatric services	
Extension 1 - Week 2	Day 71	Day 77	Day 77	No crisis call through the CARES	
Extension 1 - Week 3	Day 78	Day 84	Day 84	line Remain enrolled in IHH (as	
Extension 1 - Week 4	Day 85	Day 91	Day 91	applicable)	
Extension 2 - Week 1	Day 92	Day 98	Day 98	Adjustment Period 4:	
Extension 2 - Week 2	Day 99	Day 105	Day 105	No inpatient psychiatric services No crisis call through the CARES line Remain enrolled in IHH (as	
Extension 2 - Week 3	Day 106	Day 112	Day 112		
Extension 2 - Week 4	Day 113	Day 119	Day 119	applicable)	

NOTE: The claim cycle for Intensive In-Home Payments and Adjusted Payment Measures per HFS is in place from **10/1/2018** to **06/30/2023**.

D. Pathways to Success – An Enhanced System of Care

HFS has established a new program, Pathways to Success, that will provide services and supports to Medicaid enrolled children under the age of 21 who have an identified behavioral health need on their IM+CANS and who meet the Department's decision support criteria. The program provides access to an evidence-informed model of enhanced care coordination and additional home and community-based services. Pathways is targeted to launch on January 1, 2023.

As part of this program, HFS has integrated the following terms into the Medicaid program: <u>Care Coordination and Support (CCS):</u> An evidence-informed, structured approach to care coordination that adheres to required procedures for child and family engagement, individualized care planning, identifying and utilizing strengths and natural supports, while monitoring progress and fidelity to the Pathways to Success model.

<u>Care Coordination and Support Organization (CCSO)</u>: Provider-based organizations qualified by the Department to serve as localized, accountable hubs with responsibilities for delivering Mobile Crisis Response and care coordination to eligible customers within a Designated Service Area (DSA).

i. Pathways Provider Types, Specialty, Subspecialty and Taxonomy Codes

The tables below provide IMPACT registration details, including appropriate specialties, sub-specialties and taxonomy codes.

	CMHC and BHC Pathways to Success IMPACT Elements -Table A							
HFS Designation	HFS Provider Type	HFS Legacy Provider Type	HFS Specialty	HFS Subspecialty	HFS Legacy COS	HFS Pathways Services		
Facility, Agency,	Community Mental Health Center	036	Home and Community	Children's Services	121	Family Peer SupportRespiteTherapeutic Mentoring		

Organization (FAO)			Based Services	Intensive Home- Based	121	Intensive Home-Based
				Care Coordination & Support	122	 CCS Individual Support Services* (T1999) Therapeutic Support Services*(H0046)
Facility, Agency, Organization	Behavioral Health Clinic	027	BHC Home and Community	Children's Services	121	Family Peer SupportRespiteTherapeutic Mentoring
(FAO)			Based Services	Intensive Home- Based	121	Intensive Home-Based
				Care Coordination & Support	122	 CCS Individual Support Services* (T1999) Therapeutic Support Services*(H0046)

^{*}Services are carved out from capitation and will be paid fee-for-service (FFS) by HFS. If provider submits T1999 or H0046 on a claim to the MCO in error, these codes will deny.

CMHC and BHC Pathways to Success Acceptable Taxonomies -Table B					
HFS Provider Type HFS Legacy PT HFS indicated Taxonomy					
Community Mental Health Center	036	261QM0801X			
Behavioral Health Clinic	027	261QM0850X			

ii. Pathways Coding Guidance

Please refer to the tables below for billing Pathways services.

Pathways Specific Care Coordination and Support- billable by BHC and CMHC - Table C						
Service Description	Staff Level	HCPCS Code	HFS Legacy COS	POS Code	Units/ Maximums	HFS-required Prior Approval
Care Coordination & Support –Tier 1, High Fidelity Wraparound (HFW)*	МНР	G9001	122	99 - Other Place of Service	Only 1 Unit Monthly	OBRA Code = NB Pathways Community
Care Coordination & Support –Tier 2, Intensive Care Coordination (ICC)*	МНР	G9002	122		Only 1 Unit Monthly	OBRA Code = NM Pathways Institutional

^{*}These services must be authorized by HFS. MCOs receive a file from HFS indicating the provider authorized to provide services to the member. Only the HFS Provider ID associated with the authorization can provide the services to the member for Care Coordination & Support - HFW or ICC. NOTE:

- If approved for HFW or ICC services, the Provider CANNOT also bill T1016 Case Management Codes
- This file does NOT indicate the eligibility for other Pathways Specific Services outlined in Table D below.

Service Name	Staff	HFS COS	Place of Service Codes*	HCPCS Code	Modifiers		Units/Maximums
	Level				1	2	
Family Peer Support	RSA	121	On-site and Off-Site POS	H0038	HS		1/4 hour / 96 units daily
Respite, Individual**	RSA	121	Off-Site POS	T1005			1 hour / 7 hours daily
Respite, Group**	RSA	121	Off-Site POS	T1005	HQ		1 hour / 7 hours daily
Therapeutic Mentoring	RSA	121	On-site and Off-Site POS	H2019			1/4 hour / 96 units daily
Intensive Home Based (IHB) – Clinical	LPHA	121	On-site and Off-Site POS	S9482	TF		1/4 hour / 96 units daily
Intensive Home Based (IHB) – Clinical	QMHP	121	On-site and Off-Site POS	S9482	НО		1/4 hour / 96 units daily
Intensive Home Based (IHB) – Support	МНР	121	On-site and Off-Site POS	S9482			1/4 hour / 96 units daily
Path	ıways Spe	cific Service	s - billable by BHC and CMHC	participating in C	hild and	Family	Teams
IATP: Child and Family Team Participation	RSA or higher	006 034 058 059 116	On-site and Off-Site POS	G9007			Event: < or = to 90 mins
IATP: Child and Family Team Participation	RSA or higher	006 034 058 059 116	On-site and Off-Site POS	G9007	TG		Event: >90 mins

^{*}Refer to the Allowable Place of Service Codes table in the CBS Coding and Billing Guidelines section.

XIV. Transportation Services

A. Purpose

The purpose of this section is to outline current policies and procedures for billing non-emergency transportation (NEMT) services.

IMPORTANT NOTE: Effective with dates of service beginning April 1, 2021, emergency ground ambulance services were carved out from the MCO contracts, and effective with dates of services beginning January 1, 2022, non-emergency ambulance services have also been carved out. **MCOs ceased paying any emergency ground ambulance claims with dates of service on or after April 1, 2021 and <u>all</u> ambulance claims (COS 51) starting with dates of service on or after January 1, 2022. Claims for ALL ground ambulance services must be billed directly to HFS for HealthChoice MCO members, including MLTSS members.**

NOTE: This change does **not** impact members enrolled in an MMAI plan. Trip scheduling for non-emergency ambulance service is to be arranged by the member's MCO and/or transportation broker. Claims for non-emergency ground ambulance services not covered by Medicare should be billed to the member's MCO.

^{**} Respite services for the Pathways program are not allowed to be performed via telehealth. Modifiers GT or 93 and POS 10 or 02 are not allowed to be billed for these codes.

The service codes included, but not limited to, this HCI carve-out are as follows.

CPT Code	Description	
A0426	Advance Life Support Base Rate	
A0427	Advance Life Support Base Rate	
A0428	Basic Life Support Base Rate	
A0429	Basic Life Support Base Rate	
A0433	Advance Life Support Level 2 Base Rate	
A0434	Specialty Care/Critical Care Transport Base Rate	
A0425	Mileage associated with an above listed emergency transport	
A0422	Oxygen associated with an above listed emergency transport	

B. Provider Type

All providers must be registered in the HFS IMPACT system:

- Providers need to enroll in IMPACT for the corresponding Provider Type and Category of Service
 for any services they intend to render to an MCO patient. If providers intend to render services
 under multiple Provider Types, they need to enroll for separate Medicaid IDs using unique,
 separate NPI numbers per Provider Type. For transportation, see Table 1 below.
- Categories of Service (COS) and Specialties: Although COS is not directly added to a claim submitted to a MCO, the specialties and sub-specialties registered in HFS' Provider IMPACT system is critical to accurate claims payment. If the appropriate specialty or sub-specialties is not registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the <u>Provider Information Sheet</u> provided by HFS. For transportation, see Table 1 below.

TABLE 1: Provider Type/COS/Taxonomy Crosswalk Non-Behavioral Health Transport Services

Service	Provider Type	cos	Taxonomy
Emergency Ambulance/Helicopter/Fixed Wing/Transport Team	70	50	341600000X*
Non-Emergency Ambulance/Helicopter/Fixed Wing/Transport Team	70	51	341600000X*
Emergency Hospital Based Ambulance/Helicopter/Transport Team	74	50	341600000X*
Non-Emergency Hospital Based Ambulance/Helicopter/Fixed Wing/Transport team	74	51	341600000X*
Medicar	70,71,72,74	52	343800000X
Service Car	70,71,72,74	54	343900000X
Taxicab/Livery	72	53	344600000X
Private Automobile	73	55	347C00000X

^{*} HFS will accept the specialized taxonomies for ambulance transportation services (3416A0800X Air Transport, 3416L0300X Land Transport, 3416S0300X Water Transport

TABLE 2: Provider Type/COS/Taxonomy Crosswalk Behavioral Health Transport Services

Non-emergent behavioral health transport service	Provider Type	cos	Taxonomy
Ambulance, any type	70	056	343800000X
Ambulance Mileage	70	056	343800000X
Safety Car	70	056	343800000X
Safety Care Mileage	70	056	343800000X

C. Coding Guidance

All providers should review the **Minimum Claim Requirements** section of this manual to ensure clean claim submission.

Transportation provider services are classified as "emergency" or "non-emergency". Both emergency and non-emergency (NEMT) services can include the use of ambulances and helicopter/fixed wing transports. Non-emergency services also include Medicar, taxicab, service car, private automobile, bus, train and commercial airplane transports.

Non-emergent behavioral health transport services via "secure safety cars" and ambulance transports are services that MCOs may render to eligible members. Providers must meet the vehicle and driver minimum requirements defined via the Illinois Department of Human Services (DHS). This service is currently not a covered service under Medicaid fee-for-service.

Transportation Procedure Codes: Non-Emergent Transportation

ance	Type of Service	Description	Type of Provider	HCPCS Code	Modifier
Ambulance	Mileage	Private Auto – Per Trip Mileage (No Base Rate Allowed	Non-Ambulance	A0090	
<u>-</u>	Base Rate	Taxi	Non-Ambulance	A0100	
Non	Base Rate	Service Car	Non-Ambulance	A0120	
ent	Base Rate	Medicar (Wheel Chair Van)	Non-Ambulance	A0130	
-Emergent	Mileage	Taxi, Service Car, Medicar, Stretcher Van	As Applicable	A0425	
Ë	Attendant	Attendant	Non-Ambulance	T2001	
Non-	Attendant	Attendant (additional attendant)	Non-Ambulance	T2001	TK
Z	Stretcher Van	Stretcher Van	Non-Ambulance	T2005	

	Type of Service	Description	Type of Provider	HCPCS Code	Modifier
ergent ioral ansport	Base Rate	Ambulance, any type	Ambulance	A0999	
Emergi naviora i Trans	Mileage	BLS Mileage	Ambulance	A0380	
Non-E Beh Health	Base Rate	Safety Care	As Appropriate	A0110	
_ I	Mileage	BLS Mileage	As Appropriate	A0380	

NOTE: Non-Emergent Behavioral Health Transport refers to the DHS contract held between limited authorized providers that transport members with certain behavioral health needs which require the use of a specialized safety car or ambulance.

D. Billable Services

i. Reimbursable Services by Transportation Type

Base rate reimbursement is determined by the County in which the provider(s) is/are based/registered.

Transport Type	Reimbursable Services
Private Auto	mileage only
Taxicab	 established base rate loaded mileage rate* additional passenger/attendant
Service Car	 established base rate loaded mileage rate* additional passenger/attendant
Medicar	 established base rate loaded mileage rate* use of a hydraulic or electric lift or ramp, wheelchair lock-downs additional passenger/attendant
Stretcher Van	 established base rate loaded mileage rate* transportation by stretcher (when the member's condition does not require medical supervision, medical equipment, administration of drugs/oxygen, etc.) additional passenger/attendant
Ambulance (ALS or BLS, Specialty Care Transport/Critical Care Transport)	 community rate or established maximum rate loaded mileage rate* additional passenger(s) oxygen
Helicopter/Fixed Wing	 community rate or established maximum rate loaded mileage rate (bundled into base rate) additional passenger(s) oxygen
Unique or Exceptional Transport Type	 negotiated rates with individual MCOs

^{* &}quot;loaded mileage" is when the vehicle is carrying passengers. Loaded miles do not include miles traveled by an empty vehicle going to pick up a member, travelling between loads, or returning to home base after unloading members.

ii. Additional Attendants/Passengers

- When more than one member is transported in the same vehicle for any portion of a trip:
 - The provider may only bill mileage for the first member picked up (even if the members have different MCOs).
 - o Allowable ancillaries, if provided, may be charged (base rate only) for each member
- The use of an attendant in the transport of a member by a Medicar, service car, or taxicab is a covered service when medically necessary and approved. Attendants may be billed to respective MCOs if multiple passengers have differing enrollment (i.e. if more than one passenger is using an attendant, and the passengers have different MCOs, each MCO may be billed for the attendant use)

iii. Oxygen

• The use of oxygen in NEMT is a covered service when medically necessary and approved.

iv. Air Transport

- Helicopter transportation providers who own the helicopter and provide their own transport team may be reimbursed at a maximum rate per trip, or the usual and customary charges, whichever is less.
- Medical emergency helicopter and emergency fixed wing services must be indicated with a "Y" in box 24C if filing paper claims, or Loop 2400 SV1-09 if filing electronically.
- If a hospital provides the transport team, but does not own the helicopter, the hospital and helicopter provider will equally divide the established reimbursement rate, or the usual and customary charges of the providers, whichever is less.
- Oxygen is a reimbursable service.
- Loaded mileage will be bundled into the base rates.
- Emergency helicopter transportation claims that are denied because the member's condition does not meet medical-necessity criteria may be reimbursed at the appropriate ground rate.

v. Billing for MLTSS members

When a non-emergency transportation service is allowed by Medicare, and Medicare makes a payment, MCOs will pay the **member cost-sharing portion** of the following categories of service:

- 052 Medicar
- 053 Taxi
- 054 Service Car
- 055 Private Auto
- 056 Other Transportation

The Medicaid portion of cost-sharing for MLTSS members for **emergency and non-emergency ground ambulance transportation** should be billed directly to HFS (after Medicare adjudication)

vi. Non-covered Services

The following are not covered services:

- Non-emergency transportation where approval is required but has not been obtained
- Services medically inappropriate for the patient's condition (e.g. a taxicab when public transit is available and medically appropriate or a Medicar when a service car is warranted)
- Services of a paramedic, EMT, or nurse in addition to the basic life support (BLS) or advanced life support (ALS) services
- Transportation of a person having no medical need, other than an approved attendant
- "No show" trips (i.e. member not transported)
- Charges for wait times, meals, lodging, parking or tolls
- Transportation provided in vehicles other than those owned and operated by the provider
- Transportation services provided for a hospital inpatient who is transported to another medical facility for outpatient services not available at the hospital of origin (and the return trip to the inpatient setting). IN THIS INSTANCE, the transportation provider must seek payment from the inpatient hospital.
- Services provided by a hospital-owned and operated transportation provider, where the transportation costs are reported in the hospital's cost report for the following:

- Transportation services provided on the date of admission and date of discharge
- Transportation services provided on the date that an ambulatory procedure listing (APL)
 service is performed or an emergency room visit is made
- Trips for filling a prescription or obtaining medical supplies, equipment or any other pharmacy-related item.

NOTE: Some plans will allow for trips to pharmacies etc., when combined with a medical visit. Check with each plan individually to confirm.

vii. Physician Certification Statement (PCS)

The PCS (HFS 2270) certifies that the appropriate level of transportation is being requested and is necessary for payment and verification of the level of service for members.

Completion of the PCS form for all non-emergency transportation originating at a hospital or long-term care facility, via ground ambulance, Medicar/wheelchair van or service car transport is mandatory. This form must be completed prior to transport with a copy provided to the transportation provider at the time of transport by appropriate hospital or LTC medical staff. The PCS is not required prior to transport if a delay in transport can be expected to negatively affect the member's outcome. In these cases, the form must be provided at no charge within 10 calendar days of the request of the transportation provider. If the ground ambulance provider, medi-car provider, or service car provider is unable to obtain the required Physician Certification Statement within 10 calendar days following the date of the service, the provider must document its attempt to obtain the requested certification and may then submit the claim for payment. Acceptable documentation includes a signed return receipt from the U.S. Postal Service, facsimile receipt, email receipt, or other similar service that evidences that the provider attempted to obtain the required PCS from the patient's attending physician or other medical professional. Further information may be found here.

A PCS form may be valid for recurring ground ambulance transports for up to 60 days, while one PCS form may be valid for recurring Medicar/wheelchair van and service car transports for up to 180 days. However, if medical necessity or the level of transportation changes, a new PCS form will be required.

Long term care facilities and hospitals must maintain a copy of the PCS and, upon request, furnish assistance to the transportation provider in the completion of the form if the PCS is incomplete.

Plan Specific Instructions for PCS Form Submission:

Aetna Better Health® of Illinois	Submit to IlliniCare securely via EMAIL: VendorCompliance@Aetna Better Health of Illinois .com
Blue Cross Community Health Plan (BCCHP)	Submit to BCCHP via FAX: 877-272-3629
County Care Health Plan	PCS forms are requested in real-time at the time of the ride. When provider calls to schedule a trip, PCS forms are to be sent via Fax: 630-873-1440
Meridian	Submit to Meridian via FAX: 312-508-7249
Molina Healthcare	Electronic Claim Submission A PCS form is required to be submitted within 5 business days from submission of the electronic file. Transportation Providers for Molina IL will be provided access to the Online Claims Portal to submit their claims, view claims status, appeal denials, view check details, etc. As part of the onboarding process transportation providers will receive training on the Portal and claims submission if they are new to MTM. https://www.mtm.inc.net/providers/ Paper Claims Submission Most claims will be submitted electronically. However if a paper claim needs to be submitted please use the address below. MTM, Attention: Claims Department 16 Hawk Ridge Dr. Lake St. Louis, MO 63367 If a Hospital or LTC facility arranges a Ground Ambulance, Medicar or Service Car transport, the facility must: Complete a PCS Provide a copy to the transportation provider Transportation provider must submit the PCS with the claim in the

viii. Certificate of Transportation Services Form

Effective with dates of service on or after June 1, 2022, the Certificate of Transportation Services (CTS) form for all non-emergency transports originating at a member's private residence must be completed. HFS has standardized the form as HFS 2271. The CTS should be completed by a qualified medical professional on behalf of the customer prior to transport. A copy of the CTS should be provided to the transportation provider at the time of transport.

- The CTS may be utilized for repetitive trips. One CTS form may be valid for recurring nonemergency ground ambulance transports for up to 60 days and recurring medicar/wheelchair van and service car transports for up to 180 days. However, if medical necessity or the level of transportation changes, a new CTS form will be requested.
- The customer or requestor of transportation services should maintain a copy of the CTS and, upon request, furnish assistance to the transportation provider in the completion of the form if the CTS is incomplete.
- For non-emergency ambulance, medicar/wheel chair van or service car transport originating from a long-term care facility or hospital, an HFS 2270 Physician Certification Statement should be completed instead of the HFS 2271 CTS.

ix. Specific Claim Requirements for Transportation Providers

Claim requirements are provided in the table below. NOTE: Effective with dates of service on and after 2/1/2020, loaded mileage must be reported in Loop 2400, Segment CR106 on the 837P claim format (e.g. CR1****A*DH*10). Miles reported should be the number of one-leg loaded miles traveled from the origin to the destination site by any type of vehicle for this service. Mileage may still be reported in Loop 2300; however, it is not a requirement.

Claim Billing Requirements	 Provider Name Registered and active HFS NPI Number, For ATYPICAL providers (with no NPI) a valid Medicaid ID (837P Loop 2010BB, REF02) Ensure claims are complete in accordance with CMS and HFS requirements Member's name Member's Medicaid Recipient ID Date of service on which the transportation service was provided using the MMDDYYYY Format Utilize correct HCPCS Code (See Table) Total Charge Signature/Date of Provider Prior or Post Authorization Number (if NEMT Transportation occurs) Post Authorization Number (if Ambulance Transportation occurs) Origin and Destination Address: Paper claim example for Box 32 (Complete Address) 200 House St., Anytown, IL 60656 to Anytown Hospital, 500 Main Street, Anytown, IL 60056 For 837P — Loop 2310E, Ambulance Pick-Up Location and Loop 2310F, Ambulance Drop-Off Location Origin and Destination HCPCS Place Modifier D - Diagnostic or therapeutic site, other than P or H when used as an origin code E - Residential facility* G - Hospital-based dialysis facility H - Hospital I - Site of transfer (e.g. airport or helicopter pad) between types of ambulance* J - Non-hospital-based dialysis facility P - Physician R - Residence S - Scene of accident or acute event* X - Destination Code only. Intermediate stop at Physician's office on the way to the hospital * 5-digit zip code * Codes marked with an asterisk (*) are only allowed when billing for emergency ambulance.
	 Box 19 of paper claim form, or in the 837P format Loop 2300 (NTE) must include all of the following: State or Province Code (Use Code source 22: States and Outlying Areas of the U.S.) License Plate Number or FAA 'N' Number (Tail Number) Departure and Arrival in Military Time (time as follows: HHMM, where H = hours (00-24), M-minutes (00-59); Claim text note example MUST follow this format: NTE*ADD*IL,12345678,1155,1220 (Each element must be separated with a comma)
	FOR MOLINA BILLING ONLY: The first three digits in the text note MUST be "TR," (that is T, R, and the comma), and then follow the format above: TR, NTE*ADD*IL,12345678,1155,1220
	NOTE : The State or Province Code, Origin Time and Destination Time fields must contain the length per field as listed above. Vehicle license number may vary from one (1) to a maximum of 8 characters. If the license plate or FAA tail number is less than 8 characters, left justify and space fill.
Taxonomy	Paper claims - in Box 33B, or in 837P format - Loop 2000A PRV-03
Timely Filing	Consult Contractual Agreement with MCO
Special Indicator	Medical emergency services must be indicated with a "Y" in box 24C, Loop 2400 SV1-09

x. Transportation Vendors

MCOs often will contract out NEMT services to transportation vendors. The table below indicates MCO/Transportation Vendor relationships, including contact information.

мсо	Nemt Vendor	Contact Name	Phone	Email
Aetna Better Health® of Illinois	ModivCare	Victoria Coons	630-655-7802	CoonsV@AETNA.com
Blue Cross Community Health Plan (BCCHP)	ModivCare	Danyel Ziegel	800-530-9060	phxopsspecialist@modivcare.com
County Care	First Transit	Tameka Spence	630-403-3210	glenellynaccounting@firstgroup.com
Meridian	МТМ	Duane Williams Eric Johns		dwilliams@mtm-inc.net eric.johns@mhplan.com
Molina Healthcare	МТМ	Daisy Roman	630-203-3925	daisy.roman@molinahealthcare.com

XV. Dental

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Dental providers.

B. Provider Type

The Dental Section applies to provider type 011 Dentist.

C. IMPACT Enrollment Requirements

Provider must be a registered provider of dental services in the HFS IMPACT system.

The following provider types are approved to enroll with Dental service:

011 - Dentists

040 - FQHC

043 – Encounter Rate Clinics (ERC)

048 – Rural Health Clinics (RHC)

052 – Local Health Departments

D. Billing Requirements

i. Covered Services

Covered dental services can be located <u>here</u> and using the corresponding exhibit noted below.

Children: Exhibit AAdults: Exhibit B

Pregnant Women: Exhibit C

FQHC Denture Billing: Exhibit D

ii. Claim Form

The following information must be included on the ADA claim form/ an 837D for dental claims (if filing electronically) for timely claims processing:

- Member name
- Member Medicaid ID number

- Member date of birth
- Provider name
- Provider location and service setting
- Billing location
- NPI or Tax Identification number (TIN)
- Date of service for each service line
- ADA dental codes in the current CDT book for each service line
- Provider signature

Be sure to include all required identifiers (quadrants, tooth numbers, and surfaces) as detailed in the benefit grids for each code.

iii. MCO Dental Vendors

MCO's subcontract to Dental vendors to administer dental services to members. Below is a chart that outlines the Dental vendors and applicable contact information by MCO.

мсо	Dental Vendor
Aetna Better Health® of Illinois	Vendor: DentaQuest Phone: 800-508-6780 On-line Portal: www.dentaquest.com
Blue Cross Community Health Plan (BCCHP)	Vendor: DentaQuest Phone: 800-508-6780 On-line Portal: https://govservices.dentaquest.com/
County Care Health Plan	Vendor: Avēsis Phone: 866-337-1594 On-line Portal: www.avesis.com/commercial3/providers/index.aspx
Meridian	Vendor: DentaQuest Phone: 844-822-8110 On-line Portal: www.govservices.dentaquest.com/
Molina Healthcare	Vendor: Avēsis Phone: 866-857-8124 On-line Portal: www.avesis.com/commercial3/providers/index.aspx

iv. Claim Submission Methods

Claims can be submitted a variety of ways depending on the Dental vendor capabilities. Below is a table that outlines by MCO claim submission methods by Dental vendor.

мсо	Claim Submission Methods
Aetna Better Health® of Illinois	Vendor: DentaQuest Portal: www.dentaquest.com Electronic: Payer ID CX014 Paper: PO Box 2906 Milwaukee, WI 53201-2906

мсо	Claim Submission Methods	
Blue Cross Community Health Plan (BCCHP)	Vendor: DentaQuest Portal: www.dentaquest.com Electronic: Via Clearinghouse – Payer ID CX014 Include address on electronic claims DentaQuest, LLC PO Box 2906 Milwaukee, WI 53201-2906 Paper: P.O. Box 2906 Milwaukee, WI 53201-2906	
County Care Health Plan	Vendor: Avēsis Portal: www.avesis.com/commercial3/providers/index.aspx Electronic: Payer Identification Number: 86098 Paper: Avēsis Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300	
Meridian	Vendor: DentaQuest Portal: www.govservices.dentaquest.com/Logon.jsp Electronic: Via Clearinghouse – Payer ID CX014 Paper: P.O. Box 2906 Milwaukee, WI 53201-2906	
Molina Healthcare	Vendor: Avēsis Portal: www.avesis.com/commercial3/providers/index.aspx Electronic: Payer Identification Number: 86098 Paper: Avēsis Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300	

v. Encounter Submission for FQHCs, CHCs and RHCs

Facilities such as Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) and Rural Health Clinics (RHCs) are reimbursed through encounter payments. These providers can choose one of the four claim submission options to submit encounters. Note the following requirements:

- Claims must be submitted with D0999 for dental on the first service line of the claim.
- Submit one encounter claim for each unique member visit.
- Submit codes for every procedure performed on the encounter claim to ensure member utilization data are complete.
- Ensure every code includes corresponding tooth numbers, quads, arches and any other required identifiers.
- Include applicable authorization numbers.
- Include all documentation requirements.

vi. Hospital Setting

a) Patient Criteria

Specific criteria must be met in order to justify the medical necessity of performing a dental procedure in the outpatient setting.

The criteria are:

- The Beneficiary requires general anesthesia or conscious sedation;
- The Beneficiary has a medical condition that places the Beneficiary at an increased surgical risk, such as, but not limited to: cardio-pulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or
- The Beneficiary cannot safely be managed in an office setting because of a behavioral, developmental or mental disorder.

b) Dental Billing Procedures

- Claims must include documentation to support the medical necessity for performing the
 procedure in the outpatient setting including a narrative specifying the medical
 necessity, supporting X-rays and any other explanation necessary to make a
 determination.
- Dentists must record a narrative of the dental procedure performed and the corresponding CDT dental codes in the Beneficiary's medical record at the outpatient setting. If the specific dental code is unknown, the code D9999 may be used.
- Claims must be submitted for the covered professional services in the same format and manner as all standard dental procedures.

vii. FQHC Denture Billing

An FQHC may bill up to three additional encounters per prosthesis for a member receiving a complete or partial denture. Partial dentures are limited to children age 2 through 20 only. Use code D5899 – Unspecified Removable Prosthodontic Procedure – for eligible members receiving dentures in a FQHC facility. To receive consideration for additional reimbursement, a FQHC must submit prior authorization for a maximum of three (3) procedure codes (D5899) along with authorization for the complete or partial denture. If the authorization for the complete or partial denture is approved, the FQHC will also receive approval for up to three of the additional codes (D5899).

Appropriate Visits for Procedure Code D5899

- Initial denture impressions
- Final denture impressions
- Vertical dimension of occlusion visits
- Wax try-in visits
- Necessary adjustments post insertion
- Repairs or relines during the six (6) month period following the insertion of the new prosthesis

In each case, a narrative of the service performed must be provided at the time procedure code D5899 is billed.

Providers should submit for payment for the complete or partial denture (D5110, D5120, D5211, D5212) at the time the prosthesis is inserted.

Exam and X-rays are considered the same encounter, as radiographic interpretation is included in the initial examination.

viii. Billing for Orthodontia

Billing for the pre-treatment orthodontic exam, including x-rays charges and fees for other required documentation, can only be submitted after the determination. For approved orthodontic cases, submit using code D8660. For denied orthodontic cases, submit using code D8999.

For comprehensive orthodontic treatment of the adolescent dentition (D8080), use the date when the bands and brackets were applied as the date of service (banding date).

Periodic treatment visits (D8670) are limited to a maximum of 11 per lifetime. Providers must check member eligibility before each D8670 visit, and each D8670 must be billed according to the date of service.

For orthodontic cases that were approved before the eligible Medicaid member became a Managed Care member, the provider must submit a continuation of care for orthodontic treatment.

Periodic treatment visits (D8670) are limited to a maximum of 11 per lifetime. Providers must check member eligibility before each D8670 visit, and each D8670 must be billed according to the date of service.

For orthodontic cases that were approved before the eligible Medicaid member became a Managed Care member, the provider must submit a continuation of care for orthodontic treatment.

The Continuation of Care must include:

- 1. A copy of the prior health plan's authorization;
- 2. A copy of the provider's ledger showing reimbursement of all services provided to the member, including all remits/EOBs received;
- 3. A narrative detailing the remaining treatment plan.

New Managed Care members who were banded prior to becoming eligible for Medicaid and enrolling in a health plan can continue treatment with the current provider for the first 90 days after enrollment.

For payment consideration, the current provider must submit with the first claim:

- 1. A copy of the prior health plan's authorization;
- 2. A copy of the provider's ledger showing reimbursement of all services provided to the member, including all remits/EOBs received;
- 3. A narrative detailing the remaining treatment plan and request for continuing care; and
- 4. A W-9

The case will be reviewed with a clinical consultant. If approved, an authorization for remaining treatment benefits, based on the lifetime maximum and clinical criteria. If the current orthodontist is not an in-network provider, the member may be required to transfer to an in-network provider after the initial 90-days.

ix. Billing for Crowns and Dentures

- Crowns: the date of service must be billed according to the cementation date.
- Dentures: the billed date of service must be the "seat date"/ date of insertion.

FQHCs should refer to the FQHC Denture Billing section above.

x. Billing for Services Rendered Out-of-Office: Location Code

Billing for all services should include the **location code where services were rendered** on the ADA claim form (Box #38-Place of Treatment) or on the appropriate section of an electronic claim submission.

The code for treatment in an office setting is "11". For services provided in an out-of-service setting, such as a school or nursing home, bill with the appropriate location code.

The most common are:

- "03" for school
- "15" for mobile unit
- "22" for outpatient hospital
- "24" for ambulatory surgical center
- "31" for skilled nursing facility
- "32" for nursing facility
- "99" for "other"

A comprehensive list of locations can be found on the Centers for Medicare and Medicaid Services website: CMS Place of Service Codes.

E. Billing Limitations

- a) X-rays/Radiographs: Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a dentist specializing in treating the member's condition, and both providers do not share a common office location or billing practice.
- b) Amalgams and Resins: Restoration unbundling is not allowed. Total payment is based on the number of unduplicated surfaces restored per 30 days. Multiple one-surface restorations placed in the same tooth, on the same surface, within 30 days will be paid as a single restoration, except for allowable O-surface restorations. Restorations involving two or more contiguous surfaces should be billed with the applicable multiple-surface restoration code. Local anesthesia, tooth preparation, adhesives, liners and bases are included in the restoration payment.
- c) **Out-of-office preventive services:** Providers must be able to provide all four preventive services when rendered out-of-office: exam, cleaning, fluoride and sealants. When submitting paper claims for out-of-office preventive services, insert the appropriate place of service code into box #38 on the ADA claim form, or in the appropriate box when filing electronically.
- d) **Cost-sharing:** Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit.
- e) **Balance-billing:** Providers must accept the payment as "payment in full," and cannot balance bill members—that is, for the difference between the provider-billed amount and the amount received for payment of services from dental carrier.

f) **Missed appointment billing:** Providers are not allowed to charge members for missed appointments.

F. Prior Authorization and Pre-Payment Review

Follow the specific clinical criteria and authorization processes to manage service utilization according to medical necessity and appropriateness of care. Benefit descriptions and clinical criteria requirements for services are listed in the provider manual. Providers should measure intended services to the clinical criteria **before treatment begins to assure appropriateness of care**.

Authorization requests are considered according to the following:

Authorization Type	Conditions	What to do
Prior Authorizations	Required prior to treatment for certain codes identified in the benefit grids.	Check the appropriate benefit grid for requirements for each code and submit at least 14 calendar days prior to scheduled service. NOTE: * Molina submit at least 4 days prior to schedule service. * BCCHP does not require prior notification.
Urgent/Emergent Authorizations	Defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury.	Treat the member. Call dental vendor within two business days to report the urgent service in the member's dental record. Submit the completed claim and all required documentation as a Prepayment Review no later than 180 calendar days from service date. NOTE: * BCCHP and Meridian do not require prior notification. *Molina allows for post review of services instead of required notification.
Pre-payment Reviews/ Pre- estimates	Provider is confident that the member's condition and the clinical criteria are equivalent, and codes are (1) consistent for appropriate treatment and (2) are covered benefits.	Submit claim with all required authorization documentation within 180 calendar days from the date of service. NOTE: Providers starting treatment before authorization approval are at financial risk and may not balance bill the member if the utilization management reviewer determines conditions were not met.

Prior authorizations address eligibility issues at time of request, medical necessity, and appropriateness of care. They are not a guarantee of payment. Approval for payment is based on the member's eligibility on the date of service, dental record documentation, and any policy limitations on the date of service.

Below you will find a link to additional authorization information by MCO.

мсо	Dental Vendor Authorization Information
Aetna Better Health® of Illinois	Vendor: DentaQuest Provider Portal: https://dentaquest.com/dentists/login/
Blue Cross Community Health Plans (BCCHP)	Vendor: DentaQuest Consult the DentaQuest Office Reference Manual for details about authorizations and criteria www.dentaquest.com/getattachment/State-Plans/Regions/Illinois/IL-Dentist-Page/IL Managed-Care-ORM.pdf/?lang=en-US
County Care Health Plan	Vendor: Avēsis Portal: www.avesis.com/commercial3/providers/index.aspx
Meridian	Vendor: DentaQuest Consult the DentaQuest Office Reference Manual for details about authorizations and criteria: www.dentaquest.com/getattachment/State-Plans/Regions/Illinois/IL-Dentist-Page/IL Managed-Care-ORM.pdf/?lang=en-US
Molina Healthcare	Vendor: Avesis Portal: www.avesis.com/commercial3/providers/index.aspx Phone: 866-857-8124

i. Pre-Payment Review Authorizations

Urgent/emergent authorization requests for services that meet clinical criteria are immediately granted in situations which involve severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. Dental providers are encouraged to treat the member, call dental carrier within two business days (Molina notify within four business days; BCCHP and Meridian do not require notification services must still meet clinical criteria) to record the incident in the member's dental record, and then submit within 180 calendar days the completed claim with all required authorization documents on a the ADA claim form marked "Pre-payment Review."

ii. Prior Authorization for Orthodontia

In alignment with the Illinois Department of Healthcare and Family Services, dental carriers/vendors have Implemented an orthodontia scoring tool titled Handicapping Labio-Lingual Deviation Index (HLD). The HDL is located here (attachment H)

The HLD orthodontia scoring tool replaces the Salzmann Malocclusion Severity Assessment and the Orthodontic Criteria Index Form. Participants are required to either score a minimum of 28 points on the HLD or may automatically qualify by having one or more of the qualifiers below to be eligible to receive medically necessary orthodontia services.

The automatic qualifiers include:

- Cleft palate
- Deep impinging bite with signs of tissue damage, not just touching palate
- Anterior cross bite with gingival recession
- Severe traumatic deviation (i.e., accidents, tumors, etc.)
- Impacted Maxillary Central Incisor

Additional Orthodontia Services Information:

- A patient's eligibility could change during the course of treatment. Therefore, it is imperative that providers check MEDI on the date of each service to determine if the individual is:
 - eligible for services; and
 - o participating in fee-for-service or enrolled in an MCO health plan.
- Broken brackets are not reimbursable and are considered part of the Medicaid payment.
 Eligible participants should not be charged for broken brackets.
- Orthodontia authorizations are valid for three years. If additional time is needed to complete
 an orthodontic case, an extension must be requested. Participants will not be charged for
 the continuation of services as long as the patient remains eligible.

XVI. Psychiatric Free-Standing Hospitals

A. Purpose

The purpose of this section is to outline policies and procedures for hospitals billing for inpatient services for provider designated to provide Psychiatric Services by HFS and a hospital that holds a valid license as a psychiatric hospital and complies with the requirements stated HFS guidelines.

B. Provider Type

This section applies to providers who are registered with HFS as Provider Type 31- Psychiatric Hospitals.

NPIs

Psychiatric Hospitals are required to register their NPIs as a Provider Type 31 - Psychiatric Hospitals.

Categories of Service

Below are the allowable **inpatient** Categories of Services (COS) for institutional NPI billing:

021 Inpatient Hospital Services (Psychiatric)

Below are the allowable outpatient Categories of Services (COS) for institutional NPI billing

- 027 Psychiatric Clinic Services (Type 'A')
- 028 Psychiatric Clinic Services (Type 'B')

Although COS is not directly added to a claim submitted to a MCO, the COS and taxonomy combination that is registered in the HFS Provider IMPACT system is critical to accurate claims payment. If the appropriate COS is not registered, claims will deny.

Reporting of Hospital NPIs, Type of Bill and Taxonomies

Psychiatric Hospitals must bill services the NPI associated to the following HFS COS with the following taxonomies:

HFS Provider Type	HFS COS	Type of Bill	Taxonomy	
31	21	111, 112, 113, 114, 115,121, 122, 123, 124, 125		
31	27	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	283Q00000X Psychiatric Hospital or 273R00000X Psychiatric Unit	
31	28	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855		

C. Billing Requirements

i. Outpatient Requirements

a. After complying with this provider type, COS, type of bill and taxonomy guidance, Psychiatric Hospitals should follow billing guidance in the Outpatient Hospital section, Coding Guidance Section C, Psychiatric Services of the manual when billing outpatient services.

ii. Inpatient Requirements

a. After complying with this provider type, COS, type of bill and taxonomy guidance,
 Psychiatric Hospitals should follow the billing guidance in the Inpatient section, Coding
 Guidance Section C of the manual when billing inpatient services.

XVII. Rehabilitation Hospitals

A. Purpose

The purpose of this section is to outline policies and procedures for hospitals billing for inpatient services for provider designated to provide Rehabilitation Services by HFS and a hospital that holds a valid license as a Rehabilitation Hospital and complies with the requirements stated HFS guidelines.

B. Provider Type

This section applies to providers who are registered with HFS as Provider Type 32- Rehabilitation Hospitals.

NPIs

Rehabilitation Hospitals are required to register their NPIs as a Provider Type 32 - Rehabilitation Hospitals.

Categories of Service

Below are the allowable inpatient Categories of Services (COS) for institutional NPI billing:

• 022 Inpatient Hospital Services (Physical Rehabilitation)

Below are the allowable outpatient Categories of Services (COS) for institutional NPI billing

029 Clinic Services (Physical Rehabilitation)

Although COS is not directly added to a claim submitted to a MCO, the COS and taxonomy combination that is registered in the HFS Provider IMPACT system is critical to accurate claims payment. If the appropriate COS is not registered, claims will deny.

Reporting of Hospital NPIs, Type of Bill and Taxonomies

Rehabilitation Hospitals must bill services the NPI associated to the following HFS COS with the following taxonomies:

HFS Provider Type	HFS COS	Type of Bill	Taxonomy
32	22	111, 112, 113, 114, 115,121, 122, 123, 124, 125	273Y00000X Rehabilitation Unit or
32	29	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	283XC2000X Rehabilitation Hospital (Children) or 283X00000X Rehabilitation Hospital

C. Billing Requirements

i. Outpatient Requirements

a. After complying with this provider type, COS, type of bill and taxonomy guidance, Rehabilitation Hospitals should follow the billing guidance in the Outpatient Hospital section, Coding Guidance Section C of the manual when billing outpatient services.

ii. Inpatient Requirements

After complying with this provider type, COS, type of bill and taxonomy guidance,
 Rehabilitation Hospitals should follow the billing guidance in the Inpatient Hospital section,
 Coding Guidance Section C of the manual when billing inpatient services.

XVIII. Long Term Acute Care Hospitals (LTAC)

A. Purpose

The purpose of this section is to outline policies and procedures for hospitals billing for inpatient services for provider designated to provide Long Term Acute Care (LTAC) Services by HFS and a hospital that holds a valid license as a Long Term Acute Care Hospital and complies with the HFS guidelines.

LTACs specialize in the treatment of patients with serious medical conditions that require care on ongoing basis but no longer require intensive care or extensive diagnostic procedures.

HFS defines Long Term Stay Hospital as a Hospital that has 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.

Some examples of LTAC facilities are in the state of Illinois include:

- Kindred-Chicago- Lakeshore
- Kindred-Hospital-Chicago (Northlake Campus)
- Kindred-Hospital-Central Hospital
- Kindred-Hospital-Chicago- (North Campus)
- Kindred-Hospital- Sycamore
- Kindred-Hospital Peoria
- RML Specialty Hospital

B. Provider Type

This section applies to providers who are registered with HFS as Provider Type 30 - General Acute Care. Currently, HFS does not have a provider type that specifically delineates an LTAC provider. The facility would be represented by the presence of 'Long Term Acute Care' specialty in their IMPACT registration with the state.

NPIs

LTAC Hospitals are required to register their NPIs as a Provider Type 30- General Acute Care.

Categories of Service

Below is an example of the allowable inpatient Categories of Services (COS) for institutional NPI billing:

020 Inpatient Hospital Services (General)

Below is an example of allowable outpatient Categories of Services (COS) for institutional NPI billing

024 Outpatient Services (General)

Although COS is not directly added to a claim submitted to a MCO, the COS and taxonomy combination that is registered in the HFS Provider IMPACT system is critical to accurate claims payment. If the appropriate COS is not registered, claims will deny.

Reporting of Hospital NPIs, Type of Bill and Taxonomies

LTAC Hospitals must bill services the NPI associated to the following HFS COS with the following taxonomy:

HFS Provider Type	HFS COS	Type of Bill	Taxonomy
30	020	111, 112, 113, 114, 115, 121, 122, 123,124, or 125.	
30	024	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	284300000X (Specialty Hospital)

C. Billing Requirements

i. Outpatient Requirements

a. After complying with this provider type, COS, type of bill and taxonomy guidance, LTAC Hospitals should follow the billing guidance in the Outpatient Hospital section, Coding Guidance Section C of the manual when billing outpatient services.

ii. Inpatient Requirements

- b. Providers should submit claims following the Interim Billing Guidelines outlined in the Inpatient Hospital Section.
- c. After complying with this provider type, COS, type of bill and taxonomy guidance, LTAC Hospitals should follow the billing guidance in the Inpatient Hospital section, Coding Guidance Section C of the manual when billing inpatient services

iii. Outpatient Dialysis Note

Provider LTACs can provide COS 025 (Outpatient Services, Renal Dialysis) which will be covered in a future billing guidance release on this specific topic specifically for Dialysis as a topic. LTACs should follow HFS guidance on this COS and use the Dialysis Taxonomy codes 261QE0700X (ESRD Treatment) when billing for this service with the appropriate bill type for the outpatient dialysis.

XIX. SUPR (Substance Use Prevention and Recovery) Services

A. Purpose

The purpose of this section is to outline policies and procedures for facilities billing for services for provider designated to provide SUPR services by HFS and a facility that holds a valid license as a Department of Substance Use Prevention and Recovery provider and complies with the requirements stated HFS guidelines.

B. Provider Type

This section applies to providers who are registered with HFS as Provider Type 075- Substance Use Prevention and Recovery provider.

NPIs

SUPR providers are required to register their NPIs as a Provider Type 075- Substance Use Prevention and Recovery provider with HFS.

Appropriate SUPR Categories of Service (COS) for 837P/837I billing are listed below and need to be associated to the NPI in IMPACT.

SUPR services may only be rendered from a site that is certified by the Illinois Department of Human Services (DHS), Division of SUPR (Provider Type 075). The NPI the provider uses to bill MCO Plans must correspond to a SUPR certified site.

Providers offering both substance abuse services and mental health services from the same site may not utilize the same NPI number for billing substance use disorder services and mental health services. Mental health services must be billed under a separate NPI number from the substance use disorder services

Note: Always ensure that if you have multiple NPIs and IMPACT Medicaid IDs that they match on the claim. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, etc.

Categories of Service

Although COS is not directly added to a claim submitted to a MCO, the specialties and subspecialties registered in the HFS Provider IMPACT system are critical to accurate claims payment. If a provider does not have the appropriate specialty or subspecialties registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by HFS. Provider Type 075 (SUPR):

- 035-Alcohol and Substance Abuse Rehabilitation Services
- 106-Methadone Clinic

C. Coding Requirements

The required SUPR services covered by HFS contracted MCOs are listed in Table 1 below, along with the corresponding ASAM (American Society of Addiction Medicine) level(s) and general billing structure overview:

Table 1. SUPR Services Ov	Table 1. SUPR Services Overview			
Service Name	ASAM Level(s)	Claim Type	Unit	
Admission and Discharge Assessment	All levels	837P	1/4 hour	
Psychiatric Evaluation	All levels	837P	Event	
Psychotropic Medication Monitoring	All levels	837P	1/4 hour	
Medication Assisted Treatment (MAT)	All levels	837P	Event	
Individual - Therapy/Counseling, Substance Abuse	Level I	837P	1/4 hour	
Group - Therapy/Counseling, Substance Abuse	Level I	837P	1/4 hour	
Individual- Intensive Outpatient, Substance Abuse	Level II	837P	1/4 hour	
Group- Intensive Outpatient, Substance Abuse	Level II	837P	1/4 hour	
Rehabilitation - Adult (age 21+)	Level III.5	8371	Per Diem	
Rehabilitation - Child (age 20 or under)	Level III.5	8371	Per Diem	
Adolescent Residential	Level III.5	8371	Per Diem	
Detoxification	Level III.5	8371	Per Diem	
Withdrawal Management Waiver (Withdrawal Management Waiver)	All levels	8371	Per Diem	
Case Management Waiver SUD (Case Management Waiver)	All levels	837P	1/4 hour	
Peer Recovery Support (PRS Waiver)	All levels	837P	1/4 hour	

All outpatient SUPR services are to be submitted on an 837P claim listed in Table 1. All inpatient/residential SUPR services are to be submitted on an 837I claim, in line with the Claim Type listed in Table 1.

Appropriate SUPR Taxonomy Codes are listed below and should follow the guides as specified in this guidance for billing purposes by Claim Type tables listed in this guide:

- Provider Type 075 (SUPR):
 - 324500000X-Substance Abuse Disorder Rehab Facility-Institutional Billing
 - 3245S0500X-Substance Abuse Disorder Treatment (Children)-Institutional Billing
 - 261QR0405X-Rehabilitation, Substance Abuse-Professional Billing
 - 276400000X-Rehabilitiation, Substance Use Disorder Unit-Professional Billing

261QM2800X-Methadone-Assigns COS 106-Professional Billing

i. Diagnosis Codes

A primary diagnosis code is required on all SUPR claims. Acceptable primary diagnosis codes for SUPR claims are listed below in Table 2.

Table 2. Acceptable Primary Diagnosis Codes for SUPR Services
ICD10 (services rendered on or after October 1, 2015
F10-F19.99

ii. Professional Claims (837P)

The following billing codes (Table 3) will be accepted for all outpatient SUPR services:

Table 3. SUPR Services billing codes for 837P						
Service Name	Procedure Code	Modifier	Unit	Place of Service	Approval for member to participate from HFS?	Taxonomy
						261QR0405X or
Admission and Discharge Assessment	H0002		1/4 hour	03, 21, 22, 55, 57, 99	N/A	276400000X
-						261QR0405X or
Psychiatric Evaluation	90791		Event	03, 21, 22, 55, 57, 99	N/A	276400000X
						261QR0405X or
Psychotropic Medication Monitoring	H2010		1/4 hour	03, 21, 22, 55, 57, 99	N/A	276400000X
						261QR0405X or
Individual - Therapy/Counseling, Substance Abuse	H0004		1/4 hour	03, 22, 57,99	N/A	276400000X
						261QR0405X or
Group - Therapy/Counseling, Substance Abuse	H0005		1/4 hour	03, 22, 57 ,99	N/A	276400000X
						261QR0405X or
Individual - Intensive Outpatient, Substance Abuse	H0004	TF	1/4 hour	03, 22, 57 ,99	N/A	276400000X
						261QR0405X or
Group - Intensive Outpatient, Substance Abuse	H0005	TF	1/4 hour	03, 22, 57,99	N/A	276400000X
Medication Assisted Treatment (MAT) Methodone Treatment*	H0020		Event	11, 55	N/A	261QM2800X
Case Managment Waiver SUD (Case Management						261QR0405X or
Waiver)** (age 21 +)	H0006		1/4 hour	11, 55, 99	OBRA code = RC	276400000X
Case Managment Waiver SUD (Case Management						261QR0405X or
Waiver)**(age 20 & under)	H0006	НА	1/4 hour	11, 55, 99	OBRA code = RC	276400000X
						261QR0405X or
Peer Recovery Support (PRS Waiver) **(age 21+)	H2014		1/4 hour	11, 55, 99	OBRA code = RD	276400000X
Peer Recovery Support (PRS Waiver) **(age 20 &						261QR0405X or
under)	H2014	на	1/4 hour	11, 55, 99	OBRA code = RD	276400000X
* Provider must be approved by DHS to provide MAT se	ervices					
** Refer to 1115 Waiver Rules						

Additional professional claims (837P) claim submission requirements:

- 1. MAT services are reimbursed on an event-based basis, with a maximum of one event per week (7 calendar days).
- 2. MAT services must be submitted on a unique claim.
- 3. H2010 Psychotropic Medication Monitoring: This code should not be used for the management of methadone or any other MAT service. This code is meant to manage the use of medications for those patients who have a co-occurring mental health diagnosis and need medication to help with their condition. Methadone is not considered a psychotropic medication. Only physicians can bill for psychotropic medication monitoring. This is typically not needed every day.
- 4. The 2010AA billing loop of the 837 must contain the taxonomy code for the SUPR facility.

iii. Institutional Claims (8371)

The following billing codes (Table 4) will be accepted for all institutional/residential SUPR services:

		Procedure		Approval for member to participate from		
Service Name	Revenue Code	Code	Modifier	HFS?	Taxonomy	Type of Bill
Rehabilitation - Adult (age 21+)						
**NOTE: This program expanded to additional					324500000X or	
populations on Medicaid effective 1/1/2019	944 or 945	H0047		N/A	3245S0500X	086X, 089X
Rehabilitation - Child (age 20 or under)						
**NOTE: This program expanded to additional					324500000X or	
populations on Medicaid effective 1/1/2019	944 or 945	H0047	НА	N/A	3245S0500X	086X, 089X
					324500000X or	
Adolescent Residential	944 or 945	H2036		N/A	3245S0500X	086X, 089X
					324500000X or	
Detoxification	944 or 945	H0010		N/A	3245S0500X	086X, 089X
					324500000X or	
Nithdrawal Management Waiver**(age 21+)	944 or 945	H0012		OBRA code = RB	3245S0500X	086X, 089X
					324500000X or	
Withdrawal Management Waiver **(age 20 or under)	944 or 945	H0012	НА	OBRA code = RB	3245S0500X	086X, 089X

Additional institutional claims (837I) claim submission requirements:

- 1. SUPR residential/institutional services are to be billed as one global rate on a single 837I claim-domiciliary (room and board costs) and treatment costs should not be split nor, should they be billed to the MCOs separately.
- 2. SUPR providers are asked to comply with HFS Billing Guidance as documented in the IAMHP Comprehensive Billing Manual for <u>inpatient hospital providers</u> when submitting 837I claims.
 - a. Revenue code 944 and 945 are considered 'accommodation' revenue codes in this instance per HFS.
 - b. The units will be defined as UNITS (UN) only, not DAYS (DA) in the 837I transaction.
 - c. Should be reported on one single line at the (2400 Loop, LX1, SV2, DTP segments). See examples under #4..
 - d. This change is mandated by HFS and is effective with claims received as 9/1/2020.
- 3. Admission Date (FL 12) is the date the patient was admitted to the facility or indicates the start of care date. It must be reported on the claim regardless of whether it is an initial, interim, or final bill. On an Interim Continuing (FL 4 Type of Bill = XX3) or Interim Final (FL 4 Type of Bill = XX4), the Admission Date must be prior to the statement covers "From" date. For additional guidance refer to Inpatient Hospital Coding Guidance in this manual regarding Statement and Admission Dates.
- 4. SUPR services are to be billed with statement from and statement through dates and **ONE** applicable line level dates of service for services (LX*1).
 - a. **Example** = when billing H0047 claim should include statement from and through dates and service line detail of when the services were received. Example:

LX*1 SV2*0945*HC>H0047*20169*UN*26 DTP*472***RD8*20190401-20190427**

- Units must be defined as units (UN), not days (DA), at the line level
- b. The month statement from date and the month of statement through date must be the same month. For additional guidance refer to Inpatient Hospital Coding Guidance in this manual to the Statement and Admission Dates. See the interim claim rules and Value Code 80 rules below.
- 5. Field 14- Type of Admission or Visit- (2300 Loop CL1 Segment -CL1-01 Admission Type) must be present on the claim for SUPR providers and must be equal to 1 - 5. HFS only accept codes 1 - 5. The CMS value of 9 for 'Information Not Available' is not accepted by HFS.
- 6. If a member is being dually treated for both alcohol and substance abuse, the primary admitting diagnosis should be utilized to determine the appropriate revenue code (944 or 945) for the claim.
- 7. POA (Present on Admission) is **NOT** required for 837I SUPR claims.
- 8. Attending Physician is **NOT** required on 837I SUPR claims.
- 9. A Value Code of 80 is required on all 837I claims and should be reported as the total days of the accommodation revenue code (944 or 945).
 - a. if a member is discharged on the same day as admission, the 'Statement From' and 'Statement Through' date can be the same or equal and the Value 80 submitted on the claim should be equal to 1 with the appropriate line level revenue code and procedure code.

Value Code 80: Examples following HFS rules for 'Hospitals'

Example 1:

```
Incorrect Billing
```

```
CLM*TMGMH19146000H000000*3735***89>A>1**C*Y*Y~
                                                        ----- Bill Frequency 1 (Bill Type 111)
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190503~ Statement From - Statement To
DTP*435*DT*201904291300~
CL1*3*9*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>Y~
HI*ABI>F1120~
HI*ABF>F1220>>>>>Y*ABF>F1420>>>>>Y*ABF>F329>>>>>Y*
HI*BE>80>>>5 Provider billed 5 -Incorrect number- should be 4 -as last day (discharge date) is not counted since Bill Frequency is 1
NM1*71*1*CCCCCAR*SANDEEP****XX*1124999999~
LX*1~
SV2*0944*HC>H0047*2988*UN*5~ Units are incorrect
DTP*472*RD8*20190429-20190503~
REF*6R*1~
```

Correct Billing

```
CLM*TMGMH19146000H000000*3735***89>A>1**C*Y*Y~
                                                      ----- Bill Frequency 1 (Bill Type 111)
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190503~ Statement From - Statement To
DTP*435*DT*201904291300~
CL1*3*9*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>Y~
HI*ABJ>F1120~
HI*ABF>F1220>>>>>Y*ABF>F1420>>>>>Y*ABF>F329>>>>>Y*
```

HI*BE>80>>>4 Should be 4 -as last day (discharge date) is not counted since Bill Frequency is 1

```
NM1*71*1*CCCCCAR*SANDEEP****XX*1124999999°
LX*1°
SV2*0944*HC>H0047*2988*UN*4°
DTP*472*RD8*20190429-20190503°
REF*6R*1°
```

Example 2:

Incorrect Billing:

HI*ABJ>F1020~

CLM*TMGMH1915800YBU00000*2280.59***89>A>4**C*Y*Y~ -----Frequency 4 (Bill Type 114)
DTP*096*TM*0100~
DTP*434*RD8*20190501-20190516~ Statement From – Statement To
DTP*435*DT*201905010100~
CL1*1*9*01~
K3*D820190607D820190626~
HI*ABK>F1020>>>>>>Y~

HI*BE>80>>>16~ - Provider billed 16 -Incorrect number- should be 15-as last day (discharge date) not counted since bill frequency is 4 NM1*71*1*CXXXXX*DEBORAH****XX*123456789~

LX*1~

SV2*0945*HC>H0047*2280.59*UN*13~ Needs to be 15 because HFS does not follow 'per treatment' –
DTP*472*RD8*20190501-20190515~ HFS follows inpatient rules Room and Board accommodation rules
REF*6R*1~

Example 2:

Correct Billing:

CLM*TMGMH1915800YBU00000*2280.59***89>A>4**C*Y*Y~ ------Frequency 4 (Bill Type 114)
DTP*096*TM*0100~
DTP*434*RD8*20190501-20190516~ Statement From – Statement To
DTP*435*DT*201905010100~
CL1*1*9*01~
K3*D820190607D820190626~
HI*ABK>F1020>>>>>>Y~
HI*ABJ>F1020~

HI*BE>80>>>15~ - should be 15-as last day (discharge date) not counted since Bill Frequency is 4

NM1*71*1*CXXXX*DEBORAH****XX*123456789~

LX*1~

SV2*0945*HC>H0047*2280.59*UN*15~ DTP*472*RD8*20190501-20190516~ REF*6R*1~ Needs to be 15 because HFS does not follow 'per treatment' – HFS is follows inpatient rules Room and Board accommodation rules

iv. 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.

- If billing on an interim basis, claims must be billed monthly with month statement from
 date and the month statement through date. For additional guidance refer to <u>Inpatient</u>
 <u>Hospital Interim Claims</u> coding guidance in this manual. The month statement from date
 and the month of statement through date must be the same month.
- Patient status 30 must be billed for interim claims
- Type of Bill = XX2 or Interim- First Claim = (DOS Thru Date minus DOS from Date) + 1

- Type of Bill = XX3 or Interim- Continuing Claim = (DOS Thru Date minus DOS from Date) + 1
- On interim claims, it is allowable to include day of discharge in covered non-covered day calculations.

Providers who are eligible to bill in an interim fashion should note the following:

- Services billed should be in one-month increments
 - Example 1: 3/1/19-3/31/19
 - Example 2: with an admit date of 2/6/19
 - 2/6/19-2/28/19

Example 3: Interim First Claim, Interim Continuing Claims and Interim Final Claims

- 892/893 Bill Type- MUST BE BILLED IN MONTHLY INCREMENTS PER HFS. Statement From and Statement Through dates cannot cross months when billing on an interim basis.
- The statement from and statement through plus 1 is the value code 80 calculation
- The example below demonstrates incorrect and correct billing for a member admitted on 4/29/19 and discharged on 6/3/2019.

Incorrect Example:

```
CLM*TMGMH19146000H000000*3735***89>A>2**C*Y*Y~
                                                       ----- Bill Frequency 2 (Bill Type 112 – Interim first claim)
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190603~ Statement From – Statement To – Incorrect for interim claim – dates cannot cross months.
DTP*435*DT*201904291300~
CI 1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>Y~
HI*ABJ>F1120~
HI*ABF>F1220>>>>>Y*ABF>F1420>>>>>Y*ABF>F329>>>>>Y*
HI*BE>80>>>5~ CLAIM WILL BE DENIED 1) NOT A FULL MONTH NOT ALLOWED ANY LONGER and 2) not a 1-line claim
NM1*71*1*GR*SANP****XX*112409999~
LX*1~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*D8*20190429~
REF*6R*1~
LX*2~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*D8*20190430~
REF*6R*2~
                    Each individual date of service is no longer allowed
LX*3~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*D8*20190501~
REF*6R*3~
LX*4~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*D8*20190502~
REF*6R*4~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*D8*20190503~
REF*6R*5~
```

Correct Billing would result in 3 claims:

Claim 1

```
----- Bill Frequency 2 (Bill Type 112 - Interim First Claim)
CLM*TMGMH19146000H000000*3735***89>A>2**C*Y*Y~
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190430~ Statement From - Statement To - Full Month (billed for DOS 4/29/19 to 4/30/19)
DTP*435*DT*201904291300~
CI 1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>Y~
HI*ABJ>F1120~
HI*ABF>F1220>>>>>Y*ABF>F1420>>>>>Y*ABF>F329>>>>>Y*
HI*BE>80>>>2~
NM1*71*1*GR*SANP****XX*112409999~
LX*1~
SV2*0944*HC>H0047*1494*UN*2~
DTP*472*RD8*20190429-20190430
REF*6R*1~
```

CLAIM 2: Second claim created for the May portion of the stay:

```
CLM*TMGMH19146000H000000*3735***89>A>3**C*Y*Y~ ------ Bill Frequency 3 (Bill Type 113 – Interim Continuing Claim)
DTP*096*TM*0100~
DTP*434*RD8*20190501-20190531~ Statement From – Statement To – Full Month (5/1/19 – 5/31/19)
DTP*435*DT*201904291300~
CL1*3*5*501~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>>Y~
HI*ABJ>F1120~
HI*ABF>F1220>>>>>>Y*ABF>F1420>>>>>>Y*ABF>F329>>>>>Y~
HI*BE>80>>>31~
NM1*71*1*GR*SANP****XX*112409999~
LX*1~
SV2*0944*HC>H0047*23157*UN*31~
DTP*472*RD8*20190501-20190531
REF*6R*1~
```

Claim 3: Final claim for the June portion of the stay through to discharge:

```
CLM*TMGMH19146000H000000*3735***89>A>4**C*Y*Y~ ------ Bill Frequency 4 (Bill Type 114 - Interim Final Claim)
DTP*096*TM*0100~
DTP*434*RD8*20190601-20190603~ Statement From – Statement To – 6/1/19 though to discharge date of 6/3/2019
DTP*435*DT*201904291300~
CL1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>>Y~
HI*ABJ>F1120~
HI*ABF>F1220>>>>>>Y*ABF>F1420>>>>>>Y*ABF>F329>>>>>Y~
HI*BE>80>>>2~
NM1*71*1*GR*SANP****XX*112409999~ Only get 2 units as discharge date is not billable in this scenario
LX*1~
SV2*0944*HC>H0047*1494*UN*2~
DTP*472*RD8*20190601-20190603
REF*6R*1~
```

v. Admission/Discharge

- Admission-A clinical process that occurs after a member has completed an assessment, received a recommendation for placement into a level of care and has been accepted for such treatment. Covered services provided to patients whose assessment does not result in a substance use disorder diagnosis cannot be billed.
- Discharge-Discharge occurs when the member's treatment is terminated either by completion or by some other action initiated by the member and/or organization.

vi. Billing Linked to Level of Care

Billing to a Manage Care Organization should match the Level of Care for the member. Outpatient Care (Level 1 or Level 2) cannot be billed on the same day as Residential Care (Level 3).

Admission and discharge assessment, psychiatric evaluations, and medication monitoring may be billed on the same day for any patient in any Level of Care in accordance with stated eligibility or exceptions

- Level 3-Patient Day: No more than one patient day shall be reimbursed for any participant in a 24-hour period.
- Day of Discharge or Transfer-Level III: The day of discharge is not allowable for level 3 services.

vii. 1115 Waiver Initiatives

Illinois has outlined an ambitions strategy to improve behavioral health outcomes working with CMS for 'waiver' of federal Medicaid requirements so State government can pilot or demonstrate projects. The purpose of these demonstrations is to evaluate policy approaches such as providing services not typically covered by Medicaid or creating innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Examples of State Plan Amendments (SPAs) or pilots that have been pursued by the state are:

- Medication-assisted treatment (MAT) [approved]
- Residential/Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot-Effective 1/1/2019 which increased the members eligible for this program as well as facilities that qualify as an Institution from Mental Diseases (IMD).
- Clinically Managed Residential Withdrawal Management for individuals with Substance Use Disorder (SUD) Pilot – Effective 2/1/2019 the state will cover clinically managed withdrawal management services.
- SUD Case Management Pilot Effective 2/1/2019 the state will cover SUD case management services that assist the member to access needed medical, social, educational, and other services.
- Peer Recovery Support Services Pilot- Effective 2/1/2019- this state will cover peer recovery support services delivered by individuals in recovery from a substance use disorder (peer recovery coach) who is supervised to provider counseling support to help prevent relapse and promote recovery.

HFS provides MCOs with a weekly file (referred to as the 'Weekly OBRA File') that contains the list of approved members who are eligible for the following pilots:

- Clinically Managed Residential Withdrawal Management for individuals with Substance Use Disorder (SUD)
- SUD Case Management Pilot
- Peer Recovery Support Services Pilot

Additionally, HFS provides MCOs with a listing of facilities that are approved to perform these services. A facility must be approved by HFS to perform the services referenced in this billing guideline.

XX. Home Health Care (HHC)

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Home Health Care Agencies.

B. Provider Type

The Home Health Agency Section applies to HFS provider type 050.

Note: If you are a Home Health Provider that is also registered as a Home and Community Based Waiver Provider with HFS (HFS Provider Type 90-98), and you are billing for HCBS services, you will be required to follow the (HCBS) billing guidelines.

C. IMPACT Enrollment Requirements

Provider must be a registered provider of Home Health Agency in the HFS IMPACT system with provider type 050.

The approved categories of service and specialties in the HFS IMPACT system may include:

- 066 Home Health Services
- 011 Physical Therapy Services
- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services

NPIs

Home Health Care agencies are required to register their NPIs as a Provider Type 50 – Home Health Agency and are required to use their NPI when billing Provider Type 50 services.

Note: Always ensure the NPI on the claim matches the IMPACT Medicaid IDs on record. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, specialties etc.

Although COS is not directly added to a claim submitted to a MCO, the specialties and subspecialties registered in the HFS Provider IMPACT system are critical to accurate claims payment. If a provider does not have the appropriate specialty or subspecialties registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the <u>Provider Information Sheet</u> provided by HFS.

D. Billing Requirements

All HHC claims must be billed in an electronic format using the HIPAA10 837I format.

The Bill Type (Field 4 of UB04) should be 032X with the following potential revenue /HCPCS combinations in place since 8/1/2018:

Revenue Code	Definition of Services Performed	HCPCS	Modifier
042X	Physical Therapy	G0151	
042X	Physical Therapy Evaluation	G0151	U2
043X	Occupational Therapy	G0152	
043X	Occupational Therapy Evaluation	G0152	U2
044X	Speech-Language Pathology	G0153	
044X	Speech-Language Pathology Evaluation	G0153	U2
055X	Intermittent Skilled Nursing – Direct Skilled Services of a Licensed Nurse when RN – No modifier required if not the initial visit (see U2)	G0299	
055X	Intermittent Skilled Nursing – Direct Skilled Services of a Licensed Nurse when RN – Initial Assessment Visit	G0299	U2
055X	Intermittent Skilled Nursing – Direct Skilled Services of a Licensed Nurse when LPN –	G0300	
057X	Home Health Aid-CNA	G0156	

Key Data Field Explanations and Requirements:

The chart below highlights the claim form claim requirements and explanations. Billing guidelines describe form locator fields on a UB04 as a point of reference only. As noted above, all HHC claims must be billed in an electronic format using the HIPAA10 837I format.

Form Locator Field	Explanation	Completion Needed	Comments
01	Provider Name	Required	HFS Provider Type 50
02	Pay-To Name and Address Required if different the pay to NPI is different than the Billing Provider	Conditional	
			4-digit code required
			First digit is a leading zero
			 Second digit is the facility type which should be 3 for Home Health 03XX
			Third digit is the classifies the type of care being billed
04	Type of Bill	Required	 Fourth digit indicates the sequence of the bill for a specific episode of care. 1 for admit through discharge 2 first claim in a series (discharge status = 30) 3 ongoing series claims (discharge status = 30) 4 final series claim (discharge status not equal to 30) 7 for corrected claim
05	Federal Tax ID	Required	
06	Statement Covers Period	Required	
12	Admission Date	Optional	
17	Patient Discharge Status	Required	Examples include but are not limited to: 01= Discharge to home or self-care 03= Discharged to a Skilled Nursing Facility 20= Expired (patient died) 30=Still a patient

Form Locator Field	Explanation	Completion Needed	Comments
31-34	Occurrence Code	Conditional	
35-36	Occurrence Span Code	Conditional	
39-41	Value Codes	Conditional	
42	Revenue Codes	Required	See grid above for HHC providers
43	Revenue Code Description	Optional	
44	HCPCS/Accommodation Rates	Required	See grid above for HHC providers
45	Service Date	Required	
46	Service Units	Required	Each unit is defined as a calendar day and should match the billed units in the span/day
47	Total Charges (By Rev Code Category)	Required	
48	Non-Covered Charges	Conditional	
50	Payer	Required	Name of Managed Care Organization
51	Health Plan Identification Number	Conditional	
54 A,B	Prior Payments	Conditional	
56	NPI of Billing Provider	Required	NPI of the Billing HHC Provider registered as Provider Type 50 with HFS
57	Other (Billing) Provider Identifier	Optional	HFS legacy provider number
58	Insured's Name	Required	Member's name as it appears in MEDI
60	Recipient ID number	Required	MCO member id
64	Document Control Number	Conditional	If submitting a corrected claim, include the previous claim number here
67	Principle Diagnosis Code and Present on Admission Indicator	Required	Enter the ICD-10 code Present on Admission is NOT required for HHC
67 A-Q	Other Diagnosis Codes	Conditional	If multiple Dx on the claim, ok to include
69	Admitting Diagnosis Code	Required	ICD-10 code
72A-C	External Cause of Injury	Conditional	Include the ICD-10 when there is an external cause of injuries, poisoning, or adverse effect
76	Attending Provider Name and NPI	Required	Include the NPI of the attending provider 2310A Attending Provider Loop -Qualifier 71
78	Other	Required	HFS Requires all HFS Provider Type 50 contain the REFERRING PHYSICIAN 2310F Referring Provider Loop – Qualifier DN in Appendix G of this guide on ORP- HFS treats HH like 837P in their world need this loop from providers to submit to HFS
81	Taxonomy Number	Required	251E00000X

XXI. Home and Community Based Health (HCBS) Waiver Providers

A. Purpose

MCOs have implemented updated standard claims submission processes to be utilized for the reimbursement of services rendered by certified and enrolled Home and Community Based Services (HCBS) Waiver providers. As required by the Illinois Department of Healthcare and Family Services (HFS), HCBS Waiver providers are eligible to render covered services and must adhere to the following prescribed billing criteria to be reimbursed accordingly by MCOs.

Services Overview

The State of Illinois offers services and programs that allow members to be independent while continuing to remain in their homes. Home and Community Based Services (HCBS) may also be referred to as "waivers." This is a collaborative effort between the Illinois Department on Aging (IDoA), the Department of Human Services/Division of Rehabilitation Services (DRS), the Department of Healthcare and Family Services (HFS) and is administered by the Managed Care Organizations (MCO's).

The State determines a member's eligibility for these service programs by performing an assessment called the Determination of Need (DON). The DON is used to analyze and score the member's level of need. This scoring is the basis for the member's service plan.

There are five different waiver programs the MCO administers and for which the providers of service bill for reimbursement:

1. Persons who are Elderly- Elderly Waiver:

The Illinois Department on Aging (IDoA) operates this waiver population for person age 60 or older, who are otherwise eligible for or at risk for nursing facility care as evidenced by a DON.

2. Person with Disabilities Waiver:

The Department of Human Services/Division of Rehabilitation Services (DRS) operates this waiver population for persons (age 0-59) with disabilities (those 60 or older, who began services before age 60, may choose to remain in this waiver). MCO waiver eligibility requirements are that the member has a severe disability which is expected to last for at least 12 months or for the duration of life; Persons otherwise eligible for nursing facility as evidenced by the DON.

3. Person with HIV or AIDs Waiver:

DRS administers this waiver population for persons of any age diagnosed with HIV or AIDS; Persons otherwise eligible for hospital level of care or nursing facility as evidenced by the DON.

4. Persons with Brain Injuries (BI) / Traumatic Brain Injury (TBI) Waiver:

DRS administers this waiver population for persons of any age with brain injury; have functional limitations directly resulting from an acquired brain injury, including traumatic brain injury, infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign, neoplasm of the brain, and toxic encephalopathy; have a severe disability which is expected to last for at least 12 months or for the duration of life, and are risk of placement in a nursing facility as evidenced by the DON.

5. Supportive Living Program - SLP Waiver:

The Illinois Department of Healthcare and Family Services (HFS) operates this waiver population for persons ages 65 and older, or persons with disabilities (as determined by the Social Security Administration) age 22 and older. Individuals have been screened by HFS and found to be in need of nursing facility level of care and it is determined that a SLF is appropriate to meet the needs of the individual. Individuals must not have a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. Finally, an individual's income must be equal to or greater than current SSI and they must contribute all but \$90 toward lodging, meals, and services. Food stamp benefits may be used toward meal costs.

Note: Refer to the IAMHP Billing Manual section for <u>SLP</u> providers.

HFS identifies individuals who are eligible for waivers on the 834 enrollment files that they share with the MCO's, in addition to the workflows set up directly with IDoA, the Care Coordination Units (CCU's) and DRS.

B. Provider Type, NPI, Other Identifiers and Taxonomy Codes

The following HFS Provider Types are consider HCBS Waiver Providers that can be billed to an MCO:

HFS Provider Type	HFS Description
090	Waiver service providerElderly (IDoA)
092	Waiver service providerDisability (DHS/DRS)
093	Waiver service providerHIV/AIDS (DHS/DRS)
098	Waiver service providerTBI (DHS/DRS)

To file a claim for services that an MCO has approved for one of the five HCBS waivers described above, waiver providers are required to register as a Waiver provider with IMPACT. Many HCBS providers are considered 'atypical' by HFS' IMPACT system.

HFS IMPACT Definition of an 'Atypical' provider is:

A provider who is delivering services to Medicaid clients that are not considered to be health care services. These providers are not required to obtain an NPI (National Provider Identifier). The Centers for Medicare and Medicaid Services (CMS) defines Atypical Providers as providers that do not provide health care. This is further defined under HIPAA in Federal regulations at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of Atypical Providers reimbursed by the Medicaid program. Even if these Atypical Providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and should not receive an NPI number.

When billing HCBS services, the provider should only use their HFS' Legacy Provider Number (Medicaid ID) and should NOT send in an NPI on the claim.

MCOs will require that the HFS' Legacy Provider Number (Medicaid ID) on the claim matches the IMPACT Legacy Provider Number (Medicaid ID). MCOs will not process the claim if the Legacy Provider Number (Medicaid ID) used does not match the corresponding HFS' Legacy Provider Number (Medicaid ID) and IMPACT-registered categories of service, specialties etc. The provider's HFS Legacy Provider Number (Medicaid ID) must match the IMPACT-registered provider type that corresponds with the member's waiver type. For example, an HFS' Legacy Provider Number (Medicaid ID) registered as provider type 090: Waiver service provider—Elderly should not be billed on a claim for a member who has a TBI waiver.

A valid Medicaid ID must be on the 837P Billing Provider Secondary Identification Loop 2010BB Loop in a REF01 Segment qualified by 'G2' and the REF02 equal to the provider's Medicaid ID as registered in IMPACT for their respective waiver provider type.

If the provider has multiple registrations with HFS for provider types outside of the HCBS service realm, the provider should ONLY bill their NPI on the claim for **NON-HCBS** services.

For example, if the provider is registered as an HFS Home Health provider type (050) and registered as a HCBS service provider (090), when billing for Home Health services the provider will bill on an 837I and must use their NPI in the 2010AA Billing Loop on the 837I. When billing as HCBS with HFS

provider type 090, the claim must be on an 837P and the provider must submit their Medicaid ID <u>without</u> an NPI. Refer to the <u>Home Health</u> section for billing rules to MCOs.

Personal Assistants and Individual Providers

The MCO's work in collaboration with the member to develop an individualized care plan that may include personal assistants. The MCO's will provide care coordination and oversight of the services being provided to the member. Personal Assistants (PA's) and Individual Providers (IP's) that are not working through an agency are required to enroll in IMPACT. When seeking reimbursement, PA and IP's will not submit claims directly to the MCO's. They will be required to log their time using the electronic visit verification system and from there, the payment will be issued by the State of Illinois.

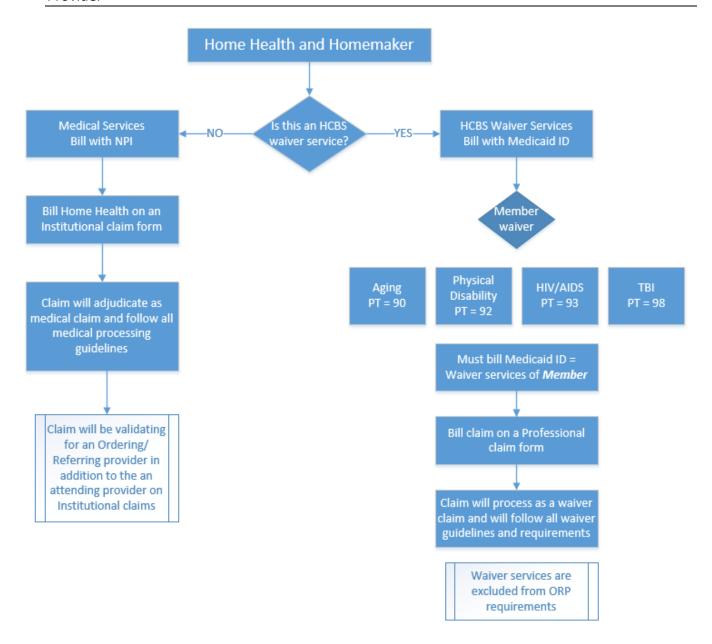
Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to a MCO, the specialties and subspecialties registered in the HFS Provider IMPACT system are critical to accurate claims payment. If the appropriate specialty or subspecialties are not registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the <u>Provider Information Sheet</u> provided by HFS.

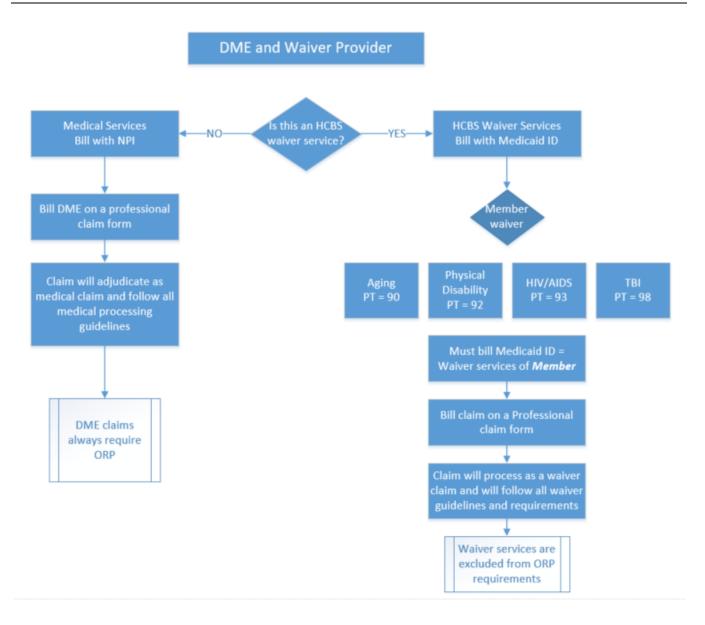
HFS Legacy Category of Service	IMPACT Subspecialty
090	Case Management
091	Home Maker
092	Agency Providers PA, RN, LPN, CAN and Therapist
093	Individual Providers PA, RN, LPN, CAN and Therapist
094	Adult Day Service
095	Habilitation Services
096	Respite care
097	Other HCFA approved services
098	Electronic Home Response/EHR installation

Diagram

Example 1: Provider who is registered in IMPACT as both a Home Health Provider and as a Waiver Provider



Example 2: Provider who is registered in IMPACT as a DME Provider and a Waiver Provider



C. General Claims Submission Requirements

Services should be billed on a CMS 1500 or an 837P electronic format. For minimum claim requirements and timely filing deadlines for Plans, see Introduction - Minimum Claim Requirements.

It is the responsibility of the provider to ensure compliance with all the service requirements of a recipient's payer, including service notifications or prior authorizations. Prior to providing Waiver services, providers should reference the MCO Provider Agreements for information on service requirements. A crosswalk of the prior authorization requirements of each of the HFS contracted Managed Care Plans can be found in the Prior Authorization section. Providers that do not comply with the service requirements of a recipient's payer may be subject to claims denial.

The following procedure codes and taxonomies are to be used for billing services by Provider type and service:

Coding Requirements

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Homemaker	\$5130		15 minutes 1 hour = 4 units	12	Υ	Y	Y	Y	91	376J00000X Homemaker 251E00000XHome health
Agency Services C N A	T1004		15 minutes 1 hour = 4 units	12		Υ	Y	Y	92	251E00000XHome Health 251J00000XNursing Care
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Υ	Y	Y	Y	94	261QA0600XAdult Day Care
Adult Day Care Transportation	T2003		1 unit is 1 trip maximum of 2 daily	99	Υ	Y	Y	Y	94	261QA0600XAdult Day Care
Respite Adult Day Care	T1005	HQ	15 minutes 1 hour = 4 units	99		Y	Y	Y	96	261QA0600XAdult Day Care 385H00000XRespite Care
Respite Adult Day Care Transportation	T1005	НВ	1 unit is 1 trip maximum of 2 daily	99		Υ	Y	Y	96	261QA0600XAdult Day Care 385H00000XRespite Care

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Respite Agency Services Home Health Aide (CNA)	T1005	SC	15 minutes 1 hour = 4 units	12		Υ	Y	Υ	96	385H00000XRespite Care 376J00000X Homemaker 251E00000XHome Health
Respite Homemaker	T1005	SE	15 minutes 1 hour = 4 units	12		Υ	Y	Υ	96	385H00000XRespite Care 376J00000X Homemaker
Respite Agency Services LPN	T1005	TE	15 minutes 1 hour = 4 units	12		Υ	Y	Υ	96	385H00000XRespite Care 376J00000X Homemaker 251E00000XHome Health
Respite Agency Services RN	T1005	TD	15 minutes 1 hour = 4 units	12		Υ	Y	Υ	96	385H00000XRespite Care 376J00000X Homemaker 251E00000XHome Health
TBI Day Habilitation	T2020		Per Diem 1 day = 1 unit	11, 99				Υ	95	261QR0400X Specialized Rehabilitation 373H00000XDay Training Habilitation Specialist 251E00000XHome Health
Prevocational Services	T2014		Per Diem 1 day = 1 unit	11, 99				Υ	95	251S00000X Community/Behavioral Health 251E00000XHome Health

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Supported Employment No Job Coach Individual	T2019		1 unit = 1 hour	11, 99				Y	95	251S00000X Community/Behavioral Health 261QR0400X Specialized Rehabilitation 251E00000XHome Health
Home Modification	\$5165		Varies with services Maximum of \$25,000.00 in a five-year period	12		Υ	Y	Υ	97	171WH0202XHome Modifications 171W00000X Contractor
Specialized Medical Equipment/Supplies Purchase	T2028		Varies with services	12, 99		Y	Y	Y	97	332B00000XMedical Equipment & Medical Supplies
Specialized Medical Equipment/Supplies Rental	T2028	RR	Maximum of \$25,000.00 on a five-year period	12, 99		Υ	Y	Y	97	332B00000XMedical Equipment & Medical Supplies
Agency Services- Individualized service provided to more than one patient in the same setting	T1002	п	15 minutes 2 hour = 8 units	12		Υ	Y	Υ	92	251E00000XHome Health 251J00000XNursing Care 282N00000XGeneral Acute Hospital 253Z00000XIn Home Supportive Care
Agency Services LPN	T1003		15 minutes 1 hour = 4 units	12		Υ	Y	Y	92	251E00000XHome Health 251J00000XNursing Care 282N00000XGeneral Acute Hospital 253Z00000XIn Home Supportive Care

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Agency Services RN	T1002		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000XHome Health 251J00000XNursing Care 282N00000XGeneral Acute Hospital 253Z00000XIn Home Supportive Care
Behavioral Services Master's Degree Level (MA)	H0004	но	Per visit with a 2- hour maximum	11, 12				Υ	97	251S00000X Community/Behavioral Health
Behavioral Services Doctoral Level (PHD)	H0004	НР	Per visit with a 1- hour max	11, 12				Y	97	251S00000X Community/Behavioral Health
Physical Therapy	G0151		15 minutes 1 hour = 4 units Maximum = 4 hours per day	11, 12		Y	Y	Υ	97	225100000XPhysical Therapist 251E00000XHome Health
Occupational Therapy	G0152		15 minutes 1 hour = 4 units Maximum = 4 hours per day	11, 12		Y	Y	Υ	97	225X00000X Occupational Therapist 251E00000XHome Health
Speech Therapy	G0153		Per visit with a 4- hour max	11, 12		Y	Y	Y	97	235Z00000XSpeech Therapist 251E00000XHome Health

HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Speech Therapy- Services delivered under an outpatient hospital speech language pathology plan of care	G0153	GN	Per visit	11, 19, 22		Y	Y	Υ	97	235Z00000XSpeech Therapist 282N00000XGeneral Acute Hospital
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99		Y	Υ	Υ	97	332U00000XHome Delivered Meals
Personal Emergency Response Install	\$5160		Per Install	12, 99	Υ	Y	Y	Y	98	146D00000XPersonal Emergency Attendant 333300000X Emergency Response System
Personal Emergency Response Monthly	S5161*		Per Month	12, 99	Υ	Y	Y	Y	98	146D00000XPersonal Emergency Attendant 333300000X Emergency Response System
Automatic Medication Dispenser	A9901		Per Install	12, 99	Υ				98	332B00000XMedical Equipment & Medical Supplies
Automatic Medication Dispenser Monthly	T1505		Per Month	12, 99	Y				98	332B00000XMedical Equipment & Medical Supplies

^{*}Exception for Molina: When services are provided on a cellular platform vs. a landline, S5161 should include the U2 modifier.

837P Submission Guidelines:

Paper Claim CMS-1500	HIPAA 5010 837P Loop	HIPAA 5010 837P Segment	Waiver Reimbursement			
Box 24b	2300	CLM05-1	Place of Service Code			
Box 24f	2400	SV1-02	Appropriate procedure code as indicated in the coding grid above			
Box 24j	2310B	NM1-09	Should not submit			
Box 31	DOES NOT MAP IN THE 837	DOES NOT MAP IN THE 837				
Box 32	2310C	NM1	Service Facility Location Information			
Box 33	2010AA	Do not send NPI in NM109 – See 2010BB Loop below	Registered HCBS Organization Name, billing address, HFS Medicaid ID, and applicable taxonomy (as registered in IMPACT). Per X12 EDI guidance NO P.O. Boxes or LOCK box permitted in this loop (2010AA)			
Box 33B	2010BB	REF01 = G2 REF02 = Provider's HFS Medicaid ID	HFS Medicaid ID for provider Example 2010BB example: REF*G2*Provider HFS Medicaid ID Paper Example 33. BILLING PROVIDER INFO & PH # (HCBS Waiver Provider 123 Main Street Springfield, IL 62704-0502 a Leave blank G2110004999999 Do not bill your NPI in Box 33A Bill your Medicaid ID in Box 33B Should use G2, no space and your Medicaid ID from HFS			
Pay to Provider No field for this on CMS 1500	2010AB	NM1*87	Pay to Provider Address (P.O. Box or Lock Boxes acceptable in this loop) **			

^{**} FOR MOLINA: Pay to Provider address must exactly match the name provided on W-9 documents. If clinic uses a 3rd Party biller to receive payments, that address must be on the W9, and the vendor must be listed as a DBA.

XXII. Vision

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Vision providers.

B. Provider Type

The Vision Section applies to provider type 062-Opticians/Optical Companies, provider type 012 – Optometrist, and provider type 010-Physician (specialty: Ophthalmologist).

D. IMPACT Enrollment Requirements

Provider must be a registered provider of vision services in the HFS IMPACT system.

Providers must have a valid NPI, be registered in the State's IMPACT system as 062-Opticians/Optical Companies, 012 – Optometrist, or 010 - Physician (specialty: Ophthalmologist) and corresponding specialties and sub-specialties. The correct taxonomy code must be included on each claim. For further information, please refer to the Manual's Introduction, Provider Types/Category of Service/Taxonomy Codes.

E. Billing Requirements

i. Covered Services

Covered vision services can be located here.

ii. Claim Form

Claims should be submitted on a CMS-1500 form or 837P format and follow all guidelines outlined in the Introduction section of this manual.

iii. MCO Vision Vendors

Most MCO's subcontract to Vision vendors to administer vision services to members. Below is a chart that outlines the Vision vendors and applicable contact information by MCO.

мсо	Vision Vendor
Aetna Better Health® of Illinois	MARCH® Vision Care Phone: 844-45- MARCH https://www.marchvisioncare.com/providerresources.aspx Provider Portal: https://providers.eyesynergy.com/Home/Landing?ReturnUrl=%2f
Blue Cross Community Health Plan (BCCHP)	DOS PRIOR TO 4/1/22: Davis Vision Phone: 888-715-6716 https://davisvision.com/ Provider Portal: https://davisvision.com/eye-care-professionals/ DOS AFTER 4/1/22: Heritage Vision Heritage Vision - Powered by VSP ® Phone: 800-615-1883 Provider Portal: https://www.vspproviderhub.com/
CountyCare Health Plan	Avēsis Phone: 866-337-1596 https://www.avesis.com/ Provider Portal: https://www.avesis.com/commercial3/providers/index.aspx

МСО	Vision Vendor				
	Meridian Network (Non-Delegated)				
Meridian	Phone: 800-654-2833				
	JAK Laboratories https://www.jakopticallaboratories.com/				
	Provider Portal: https://hpprovider.atlascomplete.com/				
	MARCH® Vision				
Molina Healthcare	Phone: 844-456-2724				
Locate a Provider https://www.MARCH®visioncare.com/					
	Provider Portal: https://providers.eyesynergy.com/Home/Landing?ReturnUrl=%2f				

iv. Medical Claims Submission vs. Vendor Claim Submission

Vision claims should be submitted to the appropriate Vision vendor as noted below. However, medical vision services claims should be submitted directly to the MCO as opposed to the Vision vendor. Vision services will be paid according to the HFS Optometry Fee Schedule.

Note: Meridiandoes not have a delegated vendor. All claims should be submitted to Meridian.

The chart below outlines some medical optical supply services that should be submitted to the MCO under the medical plan benefit, not the vision benefit.

Provider Type	Procedure Code	HFS Category of Service
062	V2623	045
062	V2624	045
062	V2625	045
062	V2626	045
062	V2627	045
062	V2628	045
062	V2629	045
012	V2623	045
012	V2624	045
012	V2625	045
012	V2626	045
012	V2627	045
012	V2628	045
012	V2629	045

v. Claim Submission Methods

Claims can be submitted a variety of ways depending on the Vision vendor capabilities. Below is a table that outlines by MCO claim submission methods by Vision vendor.

МСО	Vision Claim Submission Methods					
	Vendor: MARCH® Vision Care					
Aetna Better Health® of Illinois	Portal: https://providers.eyesynergy.com/Home/Landing?ReturnUrl=%2f					
Aetha Better Health® of Illinois	Electronic: Payor ID for Optum is 52461					
	Paper: 6601 Center Drive West, Suite 200					
	Los Angeles, CA 90045					
	Claims PRIOR to DOS 4/1/22					
	Vendor: Davis Vision					
	Portal: Provider Portal: https://davisvision.com/eye-care-professionals/					
	Electronic: VOQJA is the payer ID and Gateway (Trizetto) the clearinghouse.					
	Paper: Vision Care Plan Processing					
	Unit P.O. Box 1525					
	Latham, NY 12110					
	Claims with DOS 4/1/22 or later					
Blue Cross Community Health Plan	Vendor: Heritage Vision - Powered by VSP ®					
(BCCHP)	Electronic Provider Portal: https://www.eyefinity.com/					
	Paper:					
	In-Network Claims:					
	VSP					
	PO Box 385020					
	Birmingham, AL 35238-5020					
	Out-of-Network Claims:					
	VSP					
	PO Box 358018					
	Birmingham, AL 35238-5018					
	Vendor: Avēsis					
	Portal: https://www.avesis.com/commercial3/providers/index.aspx					
CountyCare Health Plan	Electronic: Via Clearinghouse – Payer ID 86098					
•	Paper: Avēsis Third Party Administrators, Inc.					
	PO Box 38300					
	Phoenix, AZ 85069-8300					
	Vendor: Please direct claims to MeridianPlan					
	Portal: https://hpprovider.atlascomplete.com/					
Meridian	Electronic: Via Clearinghouse – Payer ID 13189					
	Paper: 1 Campus Martius					
	Suite 720 Detroit, MI 48312					
	Vendor: MARCH® Vision					
	Portal: https://www.eyesynergy.com/					
Molina Healthcare	Electronic: Via Clearinghouse – Payer ID 52461					
inionia ricultificare	Paper: MARCH® Vision Care					
	6701 Center Drive West, Suite 790					
	Los Angeles, CA 90045					
	Lus Aligeles, CA 30045					

F. Prior Authorization

Follow the specific clinical criteria and authorization processes to manage service utilization according to medical necessity and appropriateness of care. Providers should measure intended services to the clinical criteria before treatment begins to assure appropriateness of care.

For additional information related to authorization requirements and requests, <u>refer to the General Claim Submission Guidelines for All Providers/Prior Authorization Section of the manual.</u>

Prior authorizations address eligibility issues at time of request, medical necessity, and appropriateness of care. They are not a guarantee of payment. Approval for payment is based on the member's eligibility on the date of service, vision documentation, and any policy limitations on the date of service.

XXIII. Pharmacy Providers

A. Purpose

The purpose of this section is to outline billing policies and procedures related to Pharmacy providers.

B. Provider Type

The pharmacy section applies to HFS Provider Type 060, Pharmacy.

C. IMPACT Enrollment Requirements

Pharmacy providers must be registered in the HFS IMPACT system with provider type of 060. HFS provider type 060 is eligible to fill prescriptions and can bill for DME services when the following category of service (COS) and specialties are present in the IMPACT system for that provider:

- 040 Pharmacy Services (Drugs and OTC- Over the Counter)
- 041 Medical Equipment/Prosthetic Devices
- 048 Medical Supplies

Prescribers also must be registered and enrolled in the IMPACT system in order to prescribe medications to Illinois HealthChoice members.

Although COS is not directly added to a claim submitted to an MCO, it is critical that the provider's HFS IMPACT record is registered under the correct COS or the claim will deny.

D. Billable Services

i. Retail Point of Sale (POS) Pharmacy Services – HFS Provider Type 060- Pharmacy

The pharmacy will utilize the NDCDP (National Council for Prescription Drug Programs) electronic format.

Medicaid patients can and should have access to all medications that are medically necessary. The Illinois Medicaid program covers prescription drugs, as well as some over-the-counter (OTC) drugs made by manufacturers that have a signed rebate agreement with the federal Centers for Medicare and Medicaid Services (CMS). In addition, some non-drug products are covered, which do not need to be made by a rebating manufacturer. MCOs' formularies include all drugs listed on the HFS Preferred Drug List (PDL) and may include additional outpatient drugs that individual MCOs choose to cover. All MCOs post their formularies online. As of 1/1/2020, all MCOs are required to follow HFS' PDL

Each MCO has a pharmacy benefit manager (PBM) in place for point of sale (POS) prescriptions filled at the retail pharmacy. These PBMs manage the retail point of sale claim process for Pharmacy providers. NCPDP claiming is handled via these vendor relations for each MCO.

MCO PBMs:

мсо	РВМ	Contact Information
Aetna Better Health® of Illinois	CVS Caremark	888-964-0172
BCBS	Prime Therapeutics	888-274-5218
County Care	MedImpact	888-402-1982
Meridian	CVS Caremark	888-624-1145
Molina	CVS Caremark	800-364-6331
YouthCare	Envolve Pharmacy Solutions	800-460-8988

MCO BINs and PCNs:

Plan	Carrier	BIN	PCN	Group ID
Aetna Better Health		610591	ADV	RX881A
Blue Cross		11552	ILCAID	DCFS: MM10
Community Health				Special Needs Children (SNC): MM11
Plans				MLTSS: MM03
				ACA: MM09
				Disabled Adults (ICP): MM05
				Non-Disabled Children/Adults (FHP): MM06 &
				MM07
CountyCare		017142	ASPROD1	CCX01
Meridian		004336	MCAIDADV	RX5491
Molina	0823/0829/0817	004336	ADV	RX0823/RX0829/RX0817
YouthCare		020545	RXA383	RXGMCIL01

There are some supplies per HFS guidelines that must be billed through the MCO's Pharmacy Benefit Manager (PBM). A separate listing is shown for supplies that must be billed through the pharmacy billing system with a National Drug Code (NDC). Please refer to DME Supplies That Must Be Billed Through the Pharmacy Billing System Using an NDC on HFS website.

Examples of the supplies to be billed through the PBM using and NDC are referenced below:

HCPCS	Description	
Code		
A4206	Syringe with needle, sterile 1cc or less, each	
A4207	Syringe with needle, sterile 2cc, each	
A4208	Syringe with needle, sterile, 3cc, each	
A4209	Syringe with needle, sterile 5cc or greater, each	
A4211	Supplies for self-administered injections	
A4215	Needle, sterile, any size, each	
A4245	Alcohol wipes, per box	
A4247	Betadine or iodine swabs/wipes, per box	
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips	
A4255	Platforms for home blood glucose monitor; 50 per box	
A4256	Normal, low and high calibrator solution/chips	
A4258	Spring-powered device for lancet, each	
A4259	Lancets, per box of 100	
A4614	Peak expiratory flow rate meter, hand held	
A4627	Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler	
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	
	Enteral formula, for pediatrics, used to replace fluids and electrolytes, (e.g., clear	
B4103	liquids), 500 ml = 1 unit	
E0607	Home blood glucose monitor	
E2100	Blood glucose monitor with integrated voice synthesizer	
E2101	Blood glucose monitor with integrated lancing/blood sample	

ii. HFS Provider Type 060- Billing for Durable Medical Equipment via the Medical Claim Process Pharmacies must be registered in IMPACT with the following COS or specialties in order to bill an MCO for DME via the medical claim process.

041 – Medical Equipment/Prosthetic Devices

• 048 – Medical Supplies

The charges must be submitted on a CMS 1500 form or 837P electronic claim. Pharmacy providers can refer to the <u>'General Claim Submissions Guidelines'</u> in this manual for greater clarity on this claim format.

Some examples of DME supplies/service that can be billed to the MCO include:

- Food Thickeners B4100
- Parenteral Nutrition Administration Kit B4224
- External Insulin Infusion Pumps A4230, A4231
- Gastro/JeJunoTube B4088
- Enteral Feeding Supply Kit B4035

iii. Infusion Therapy Services

Infusion therapy equipment and supplies, such as ambulatory infusion, stationary infusion and enteral nutrition pumps all qualify as DME services the pharmacy can bill under the medical plan. All supplies needed to maintain IV access *are included* in the infusion pump codes and **cannot be billed separately**. This includes items such as:

alcohol pads IV start kit, tape

betadine swabs

IV cannulas (peripheral line)
sharp containers

needleless system supplies

sterile gloves needles

dressing change kits cassette with tubing

flushing syringes TPN bag

vial adapters administration set with filter extension sets metered delivery tubing

The maximum allowable rate for each code is a flat rate regardless of number of medications or amount of supplies needed. The following supplies are permitted to be billed separately:

- a thermometer
- one box of 100 non-sterile gloves per month
- non-coring Huber like needles

Refer to the <u>Illinois HFS DME fee schedule</u> for the complete listing of covered codes that can be submitted on the MCO medical claim platforms.

IMPORTANT NOTE REGARDING IV DRUGS:

Pharmacies *cannot bill drug codes* to the medical plans. Some examples of common IV drugs that cannot be billed to the MCO include:

HCPC Procedure Code	Description	GPI
J7121	DEXTROSE 5% IN LACTATED RINGERS	9270070102120
J3285	TREPROSTINIL INJ SOLN 200 MG/20ML (10 MG/ML)	16220020312040
J1569	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 30 GM/300ML	21500011002120

iv. Specialty Pharmacies

At this time, HFS does not have a specific IMPACT provider type for specialty pharmacy or IV Infusion that allows for Medicaid reimbursement. Specialty pharmacies should register in IMPACT as Provider Type 060 to dispense and bill any covered specialty medications. Specialty pharmaceuticals (when medically necessary) are a Medicaid covered benefit. Practitioners that need to order specialty medication that must be administered via a practitioner's office, should contact each MCOs PBM for specific directions on acquiring the medically necessary pharmaceuticals covered via the pharmacy benefit. For example:

Patient needs Synagis as part of CPT Code 90378. This CPT procedure code is not found on the Illinois Practitioner Fee Schedule, so this is not considered a 'buy and bill' physician-stocked drug that would function as indicated in the next section on 'Practitioner Administered Drugs'. As a result, the practitioner should contact the MCO PBM for information on how to have the prescription for this drug filled via the PBM process and then have the drug shipped to the practitioner's office via the Pharmacy Benefit.

v. Practitioner Administered Drugs

Reimbursement for certain practitioner-administered drugs may be made to practitioners (i.e. HFS provider type 010). The drug must have been purchased by the practitioner and must be administered in the office setting in order to be submitted on the professional claim to the MCO. Reimbursement for these services will be based on the HFS PRACTITIONER FEE SCHEDULE. Submit the appropriate CPT or HCPCS Code(s) to identify the drug. When a specific code is not available, an unlisted medication CPT code may be used. The corresponding description field must contain the name of the drug, strength of the drug and amount given.

vi. Drug Wastage and 340B Purchased Drugs

Drug Wastage

Drug wastage refers to the drug amount that is discarded and not administered to any patient. Single-dose or single-use vial is a vial of medication intended for administration by injection or infusion that is meant for use in a single patient for a single procedure. CMS encourages physicians, hospitals and other providers and suppliers to administer drugs and biologicals to patients in such a way that these are used most efficiently, in a clinically appropriate manner. When a physician, hospital or other provider or supplier must discard the remainder of a single-use vial or other single-use package after administering a dose/quantity of the drug or biological to a patient, the program provides payment for the discarded drug or biological amount as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

The JW modifier is used to identify the drug amount remaining from a single use vial that is discarded after the patient receives the prescribed dosage of the medication. This must be included on the same claim as the charge for the drug amount that was administered to the patient.

When submitting claims, units of service (UOS) should be reported in multiples of the dosage included in the HCPCS code descriptor. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the number as a multiple.

If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, HFS may cover the amount of the drug

discarded along with the amount administered. The following elements must be followed in order for the discarded amount to be covered:

- The vial must be a single-use vial. Multi-use vials are not subject to payment for any discarded amounts of the drug.
- The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient, while minimizing any wastage.
- Any amount of drug billed as wastage from a single-dose vial, must actually be discarded and may not be used for another patient regardless of whether or not that other patient has Medicaid.
- Medicaid requires discarded drugs be reported with the JW modifier on a separate line, the total number of discarded units reported should not include amounts of the drug also included on the administered line due to the rounding up of units.
- Milligrams administered to the patient must be reported and then convert to the proper units for billing.
- The JW modifier is only applied to the amount of the drug or biological that is discarded. A situation in which the JW modifier is *not permitted* is when the actual dose of the drug or biological administered is less than the billing unit.

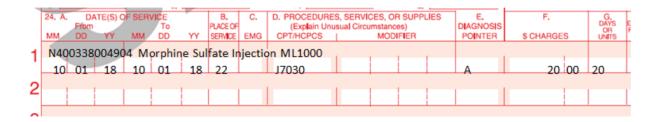
340-B Purchased Drugs

Effective with dates of service on and after July 14, 2014, providers must identify **ALL** 340-B purchased drugs by reporting modifier "**UD**" as the FIRST modifier listed after the HCPCS drug code on the CMS-1500 or 837P claim format. The provider should bill the actual acquisition cost of the drug plus the dispensing fee.

vii. Practitioner CMS 1500 Claims Submission

Practitioners administering drugs in an office setting must bill the MCO. The charges must be submitted on CMS 1500 form or 837P claim, if submitting electronically and must contain the name of the medication and the corresponding NDC number. The claim must be submitted with NDC number without hyphens, unit of measurement, and corresponding HCPCS code.

See CMS 1500 excerpt claim example below:



XXIV. School-Based/Linked Health Centers

A. Purpose

The purpose of this section is to outline current policies and procedures for School Based/Linked Health Center (SBLHC) billing.

B. Provider Type

School Based/Linked Health Center (SBLHC) services must be provided by a clinic enrolled with IMPACT as Provider Type 056 - School Based/Linked Health Centers.

C. HFS IMPACT Enrollment Requirements

Category of Service

The allowable Categories of Service (COS) are:

- 001 Physician Services
- 030 Healthy Kids Services
- 002 Dental Services
- 102 Dental Fluoride

Although COS is not directly added to a claim submitted to a MCO, it is critical that the provider's HFS IMPACT record is registered under the correct COS or the claim will deny.

Taxonomies

261QS1000X - Student Health Center

D. Coding Requirements

All claims must contain the following:

- Provider NPI SBLHC services should be billed under the site specific health center NPI.
 - Ensure that if you have multiple NPIs and IMPACT Medicaid IDs that they match on the claim.
 MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, etc
- Taxonomy Code 261QS1000X
- Category of Service
 - o 001 Physician Services
 - 030 Healthy Kids Services
 - 002 Dental Services
 - 102 Dental Fluoride
- Place of Service 03 School
- T.O.S. (Type of Service) Only the following codes are allowable for SBLHC:
 - ∘ 1 Medical Care
 - 2 Surgery

E. Covered Services

- i. The following are the covered services for SBLHCs:
- Basic medical services

- EPSDT
- Reproductive health
- Mental health
- Substance abuse
- Dental
- Fluoride varnish

For corresponding and allowable procedure codes for the services noted above, click here: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/SBLHC Fee Schedule. aspx Please note that the link also incudes a key to the fee schedule notes indicators.

Pharmacy Services

The center may bill for injectable drugs and birth control devices only when they have been purchased by the center. Providers must bill with the appropriate NDC code units and quantity when the CPT code on the fee schedule has a Y in the NDC column.

For additional instructions related to NDC billing requirements, refer to the Outpatient Hospital section v Pharmacy and Reporting of National Drug Codes

Authorization may be required for oral or injectable drugs. Refer to each MCO's authorization requirements to determine if an authorization is needed. See General Claim Submission Guidelines for All Providers section iii Prior Authorization.

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 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 bill for laboratory tests performed by any outside laboratory. Claims are not to be submitted when a specimen is obtained by center staff and sent out of the office.

Vaccinations

For detailed information on how to appropriately bill for vaccinations, refer to the SBHLC fee schedule key. Also, this link provides billing scenarios provided by HFS for your reference:

https://www.illingis.gov/bfs/SiteCollectionDocuments/81310Attachment/FCBillingChangesExamplesE

https://www.illinois.gov/hfs/SiteCollectionDocuments/81219AttachmentVFCBillingChangesExamplesFinal.pdf

XXV. Birthing Centers

A. Purpose

The purpose of this section is to outline current policies and procedures for Birth Centers.

B. Provider Type

Birth Center services must be provided by an outpatient clinic enrolled with IMPACT as **Provider Type 019- Birth Center**

C. HFS IMPACT Enrollment Requirements

Category of Service

The allowable Categories of Service (COS) are: 024 – Outpatient Services (General).

Although COS is not directly added to a claim submitted to a MCO, it is critical that the provider's HFS IMPACT record is registered under the correct COS or the claim will deny.

Taxonomies

261QB0400X (Birthing Center)

D. Covered Services

The following are the covered services for Birth Centers:

- 1. Delivery Services
- 2. Observation Services
- 3. Transfer Fee

E. Coding Requirements

Birth Centers claims must be submitted on a UB-04 claim form or in the 837I electronic claim format. See General Claim Submission Guidelines for All Providers can be found here.

All claims must contain the following:

- Provider NPI Birthing services should be billed under the site specific health center NPI.
- Taxonomy Code 261QB0400X (Birthing Center)
- Category of Service: 024 Outpatient Services (General)
- Type of Bill: Only valid TOB = 0841 (admission through discharge claim)

Revenue Code	Procedure Code
0724 – Birthing Center For delivery and transfer services	59409 – Delivery Services S4005 - Transfer Fee
0762 – Observation Hours For observation services	One of the following procedure codes must be identified on the claim: 99218; 99219; 99220; 99234; 99235; or 99236 *minimum unit = 1 hour

F. Billing Scenarios

Claims containing more than one type of birth center service will be adjudicated according to the following hierarchy:

- Claims containing a delivery procedure and an observation service will be adjudicated based on the highest-payable service, which is the delivery.
- Claims containing observation and a transfer to a hospital will be adjudicated based on the highest-payable service, which is the transfer.

Transfer from Birth Center to Hospital for Delivery

The patient was admitted to the birth center but due to complications was transferred to the hospital. The following claim fields need to be completed for proper claim adjudication:

- FL 4 Type of bill. Enter "0841" (admission through discharge claim.)
- FL 6 Statement Covers Period.

FL 44 – Appropriate Procedure Code for a transfer (S4005)

Observation with Transfer

The patient was placed in observation at 9:00 P.M. on March 3, 20XX. At 5:00 A.M. the birth center staff made the decision to transfer the patient to a hospital due to unforeseen complications. The following claim fields need to be completed for proper claim adjudication:

- **FL 42** Revenue Code. Use Revenue Code 0762 for observation services. Use Revenue Code 0724 for the transfer service.
- **FL 44** HCPCS/Accommodation Rates. Use valid procedure codes for the observation and the transfer services as shown in the Birth Center Fee Schedule.
- **FL 46** Service Units. The patient was in observation for eight hours. An entry of "8" must be identified in this field.

Note: As the rate for the transfer fee is higher than the rate for the observation period, the claim will be adjudicated at the transfer fee rate.

XXVI. Specialized Mental Health Rehabilitation Centers (SMHRFs)

A. Purpose

The purpose of this section is to provide guidance on current policies and procedures for billing by Specialized Mental Health Rehabilitation Facilities (SMHRFs).

B. Provider Type

This section applies to providers registered in HFS's IMPACT system as **Provider Type 038** - Intermediate Care Facility, Mental Illness. Providers should use the 310500000X (Intermediate Care Facility, Mental Illness) taxonomy code

C. Category of Service

The allowable Categories of Service (COS) is 071 - LTC Intermediate

Although COS is not directly added to a claim submitted to a MCO, it is critical that the provider's HFS IMPACT record is registered under the correct COS or the claim will deny.

D. Long Term Care (LTC) / SMHRF Eligibility

A Medicaid recipient must be assessed, and their determination of need (DON) must be approved to qualify for long term care services. The MCOs do not determine eligibility for long term care services. Although HFS determines eligibility for services, many MCOs have a notification or authorization requirement related to the admittance to the facility. Providers must comply with MCO specific notification requirements.

E. Patient Credit File

The Patient Credit File (PCF) is submitted to Managed Care Organizations (MCOs) weekly by the Department of Healthcare and Family Services (HFS). The PCF incorporates data regarding eligible services rendered to a MCO's membership for a rolling 36-month period. The PCF is composed of individual member segments, each of which relay the following information:

Recipient Identification Number (RIN)

- Last Name
- First Name
- LTC Provider ID
- Patient Credit Segment Begin Date
- Patient Credit Segment End Date
- Patient Credit Amount
- Provisional Eligibility Indicator (Conditional)

The PCF is a MCO's source of truth for validation.

- HFS notifies the MCOs of patient income responsibilities via the weekly patient credit file (PCF).
- The member and the SMHRF provider must be on the patient credit file for the provider to
 receive payment. All SMHRF claims are reviewed for patient liability using the patient credit file
 and the payment to providers will be reduced should the member have income liability on the
 date of service.

F. Coding Requirements

- All SMHRF claims must be billed in an electronic format using the 837I electronic claim format.
- Covered Services/Revenue Codes
 - Revenue codes 0110-0160: General room and board

 NOTE: Effective with dates of service 7/1/22, in order to receive any applicable add-on payments, facilities must use the appropriate revenue code indicating single (0110) or double (0120) occupancy rooms.
 - Revenue code 0182: Leave of Absence Patient Convenience (not reimbursable)
 - o Revenue code 0183: Leave of Absence Therapeutic Leave
 - Revenue code 0185: Hospitalization (not reimbursable)
- Leave of Absence
 - Only a therapeutic leave of absence (LOA) will be reimbursable (rev code 0183)
- Value Codes
 - Values codes must be used to illustrate the members length of stay.
 - 80 = must equal "covered days"
 - 81 = any non-covered days
 - Services must be billed in increments that do not exceed one calendar month.
 - See value code claim examples in the chart below (Field 39-41). Examples will illustrate how to enter various dates of service.
 - Example 1: DOS = 3/1/19-3/31/19 and no LOA
 - Example 2: DOS = 3/1-3/31/19 with 5 LOA days

The chart below describes form locator fields on a UB04 as a point of reference with key data field explanations and requirements:

Form			
Locator	Explanation	Completio n Needed	Comments
Field			
01	Provider Name	Required	
02	Pay-To Name and Address Required	Conditional	
04	Type of Bill	Required	4-digit code required 065X: Intermediate Care
			X= 1 for admit through discharge X=2 first claim in a series (discharge status = 30) X=3 ongoing series claims (discharge status = 30) X=4 final series claim (discharge status not equal to 30) X=7 for corrected claim
05	Federal Tax ID	Required	
06	Statement Covers Period	Required	Billed in no more than a 1-month increments
12	Admission Date	Required	If bill type ends in 1, statement from date and admit date <u>must</u> match If bill type ends in 2, statement from date and admit date <u>must</u> match If bill type ends in 3 or 4, statement from date and admit date <u>cannot</u> match and must be the original admission date
17	Patient Discharge Status	Required	Examples include but are not limited to: 01= Discharge to home or self-care 03= Discharged to a Skilled Nursing Facility 20= Expired (patient died) 30=Still a patient
31-34	Occurrence Code	Conditional	55 when billing patient discharge status = 20
35-36	Occurrence Span Code	Conditional	74 only when billing a LOA Must have a LOA revenue code on the claim 018X and value code 81.
39-41	Value Codes	Required	Include dates of the LOA 80 = must equal "covered days" 81 = any non-covered days
			Example 1: 3/1-3/31/19 No LOA days, therefore, value code 80 should be reported with a unit value of 31. Example 2: 3/1-3/31/19 with 5 LOA days, therefore value code 80 should be reported with a unit value of 26 and value code 81 should be reported with a unit value of 5 and required 74 Occurrence Span Code and revenue code 018X. Both scenarios created a total of 31 units
42	Revenue Codes	Required	Rev code 0110-0160 = General room & board Rev code 0182 = LOA for patient convenience Rev code 0183 = LOA for therapeutic leave Rev code 0185 = LOA for Hospitalization Use Rev Code 0110-0160 for each day the member was in the facility. Total units of this series should equal the units for value code 80.
			Use Rev Code 018X for all LOA days, and the total should equal the units of value code 81. If there is a therapeutic revenue code 0183, this will still be calculated into non-covered days, and the number of units would be used with value code 81
43	Revenue Code Description	Required	
44	HCPCS/Accommodation Rates	Optional	

Form Locator Field	Explanation	Completio n Needed	Comments	
45	Service Date	Required	Ok to bill for the span such as 3/1-3/31/19 if days are consecutive. When there is a LOA, must group service dates, rev codes, together when consecutive.	
46	Service Units	Required	Each unit is defined as a calendar day	
47	Total Charges (By Rev Code Category)	Required		
48	Non-Covered Charges	Conditional		
50	Payer	Required	Name of Managed Care Organization	
51	Health Plan Identification Number	Conditional		
54 A,B	Prior Payments	Conditional		
56	NPI of Billing Provider	Required	NPI of the Billing SMHRF Provider	
57	Other (Billing) Provider Identifier	Optional	HFS legacy provider number	
58	Insured's Name	Required	Member's name as it appears in MEDI	
60	Recipient ID number	Required	MCO member id	
64	Document Control Number	Conditional	If submitting a corrected claim, include the previous claim number here	
67	Principle Diagnosis Code and Present on Admission Indicator	Required	Enter the ICD-10 code Present on Admission is NOT required	
67 A-Q	Other Diagnosis Codes	Conditional	If multiple diagnosis on the claim, ok to include	
69	Admitting Diagnosis Code	Required	ICD-10 code	
72A-C	External Cause of Injury	Conditional	Include the ICD-10 when there is an external cause of injuries, poisoning, or adverse effect	
76	Attending Provider Name and NPI	Required	Include the NPI of the attending provider	
81	Taxonomy Number	Required	310500000X Intermediate Care Facility, Mental Illness	

XXVII. Professional Services

A. Purpose

The purpose of this section is to outline current policies and procedures for practitioners rendering medical services billing.

NOTE: Additional billing guidelines are available for many of the provider types and categories of service noted in this section. All billing guidance must be followed. Refer to the appropriate provider type in this manual for additional guidance.

B. Provider Type

Provider must be Enrolled as HFS provider type:

010 - physician

089 - physician assistant (PA)

016 - advanced practice nurse (APN)

064- imaging center

065- independent diagnostic testing facility

056 - school-based linked health center

052 - local health department

061- independent laboratory

030,031,032 - fee-for-service hospital (Prior to July 1, 2020, only)

012 - optometrist providing medical services

011 - dentist providing medical services

C. HFS Provider Enrollment Requirements

Category of Service (COS)

Although COS is not directly added to a claim submitted to an MCO, the specialties and subspecialties registered in the HFS Provider system are critical to accurate claims payment. If the appropriate specialty or subspecialties are not registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by HFS.

Category of Service

001	Physician Services
002	Dental Services
003	Optometric Services
006	Physicians Psychiatric Services
017	Anesthesia Services
018	Midwife Services
019	Genetic Counseling
026	General Clinic Services
030	Healthy Kids Services
042	Family planning service
043	Clinical Laboratory Services
044	Portable X-Ray Services

Taxonomies

All claims must include the 10-character specific provider taxonomy code (e.g., 207Q00000X for Family Practice, 282N00000X for General Acute Care Hospital) to be processed. Information and listings of provider taxonomy codes are available by clicking here.

D. Claim Submission Requirements

The Illinois Department of Healthcare and Family Service (HFS) requires Managed Care Organizations (MCO) to meet specific claim submission standards requiring exact data elements on claims submitted for professional services. For claim submission guidelines please refer to the General Claims Submission Guidelines for All Providers in this guide. All professional claims are to be submitted using a CMS-1500 paper claim form or an 837P electronic claim format.

Billing and Rendering Providers

Billing Provider

The Billing Provider represents the *payee* on an individual claim. The Billing Provider NPI must correspond to the payee ID where a provider wants remittance advice and payments to be sent (e.g. group practice or clinic). The Billing Provider NPI should be reported in loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form.

Rendering Provider

The Rendering Provider represents the individual provider or clinician who provided the services detailed on the claim. The NPI for the Rendering Provider must be reported if the Billing Provider NPI corresponds only to a payee ID (see above) or to a rendering provider different from the provider who rendered the service billed. The Rendering Provider is reported in loop 2310B on 837P submissions or Box 24J on a CMS 1500 form.

Ordering, Referring, Prescribing (ORP) Providers- National Provider Identifier (NPI) Requirements

Effective with dates of service on and after August 1, 2020, if the ORP's provider's name and NPI are not on the claim or if the claim contains information for an ORP who is not enrolled in IMPACT, the claim will reject, and the provider will not receive reimbursement for services. It is the responsibility of the rendering provider of service to validate that the ORP is active and registered in IMPACT. This is also effective for pharmacy claims. The prescriber identified on the claim must also be enrolled in IMPACT. Specific instructions can be found in the HFS provider notice located here, and a registered provider look-up tool is available here. See additional information on ORP in Appendix G of the billing manual.

Claim format specifics for ORP include:

For professional claims on an 837P

- Referring provider is required when submitted at claim level 2310A or service line 2420F: qualifier DN
- Ordering Provider is required at service line level 2420E: qualifier DK

• If a paper CMS1500 form is used, the ORP name should be in box 17, the qualifier in box 17a and the NPI should be in box 17b.

Effective with dates of service beginning July 1, 2020, all services rendered by a PA must be billed by the PA's employer utilizing the name and National Provider Identifier (NPI) of the PA as the rendering provider. The billing name and NPI must be of the PA's employer. PAs must be enrolled in IMPACT as Rendering/Servicing providers.

Allowable Practitioner Claims

A practitioner may charge only for services personally rendered by that provider, or that are provided under the practitioner's supervision in the practitioner's office by ancillary licensed or certified staff not eligible for individual enrollment, e.g., a vaccination administered by a registered nurse in the practitioner's employ. A practitioner may not charge for services provided outside the practitioner's office by anyone other than the practitioner with the following exceptions:

A physician may submit a bill for services rendered by an Advanced Practice Nurse (APN) or a Genetic Counselor, if such practice is not in conflict with the following rules and regulations:

- Genetic Counselor Licensing Act (225 ILCS 135)
- Nurse Practice Act [225 ILCS 65]

NOTE: Effective September 1, 2021 claims must identify the APN as the rendering or ordering/referring/prescribing provider as applicable with the APN's name and NPI. Services may not be billed under the collaborating physician's name and NPI.

Teaching Physicians

Teaching physicians who provide direct patient care may submit charges for the services provided if the salary paid to them by the hospital or other institution does not include a component for treatment services. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment. Charges are to be submitted only when the teaching physician seeking reimbursement has been personally involved in the services being provided using the physician's NPI.

Hospital Salaried Practitioners

Inpatient services rendered by hospital salaried practitioners may be billed separately if their salary is not included in the hospital's cost report for direct patient care. If the physician's salary is included in the hospital's cost report for direct patient care, the services of the salaried physician are included in the hospital's reimbursement. A claim may be submitted for one salaried physician involved in direct patient care in any outpatient setting in conjunction with an outpatient procedure. If more than one salaried physician provides services to the same member, the services provided by additional salaried physicians are considered part of the all-inclusive rate and cannot be billed as fee-for-service.

This excludes billing for a salaried pathologist, radiologist, nurse practitioner or certified registered nurse anesthetist (CRNA).

Residents

When a resident provides medical services to an MCO member, a claim can be submitted only when billed under the teaching physician's NPI along with the GC modifier. The teaching physician must: 1) be personally involved in the patient's care; and 2) directly supervise the resident's activities.

Services performed by a resident without the presence of a teaching physician must be billed under the teaching physician's NPI along with the GE modifier.

Hospital-Owned Off-Site Facility Facilities Located within 35 Miles of the Hospital

For dates of service prior to 7/1/2020, hospital billing charges may be submitted for services provided at an off-site hospital-owned clinic, express care, or urgent/priority care facility. The hospital may bill facility charges for procedures from the Ambulatory Procedures Listing (APL) as described in the Handbook for Hospital Services.

All professional services such as office visits must be billed by the practitioner who rendered the service and not the hospital.

Facilities Located More Than 35 Miles from the Hospital

A salaried practitioner may submit charges for the services provided at an off-site hospital-owned clinic, express care, or urgent/priority care facility. The salaried practitioner may submit charges for office visits and for only the technical component of any laboratory or radiology services performed. The interpreting practitioner must submit charges for the professional component of the laboratory and radiology services. Charges submitted for any office visits, laboratory or radiology services performed must be submitted with place of service 11 - office.

340B Providers

An HFS enrolled provider who is eligible to participate in the 340B Federal Drug Pricing Program, as defined in Section 340B of the federal Public Health Services Act (https://www.hrsa.gov/opa/), shall enroll in that program. HFS enrolled providers who are also enrolled with the Department of Health and Human Services as a 340B provider must use 340B purchased drugs for Medicaid covered members.

An HFS enrolled provider who is also enrolled in the 340B Federal Drug Pricing Program must charge no more than the actual acquisition cost for the drug product plus the appropriate established 340B dispensing fee as noted on the <u>Practitioner Fee Schedule</u>.

Providers must identify 340B purchased drugs by reporting modifier "UD" in conjunction with the appropriate drug Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

E. Covered Services

A covered service is a service for which a claim can be submitted and adjudicated. Covered services are in accordance with 89 Ill. Adm. Code 140.3

Non-Covered Services

Services for which medical necessity is not clearly established are not covered. Services that are non-covered include:

- Services available without charge
- Services prohibited by State or federal law
- Experimental procedures
- Research oriented procedures
- Medical examinations required for entrance into educational or vocational programs
- Autopsy examinations
- Artificial insemination
- Medical or surgical procedures performed for cosmetic purposes
- Medical or surgical transsexual treatment, for dates of service prior to April 1, 2015
- Diagnostic and/or therapeutic procedures related to primary infertility/sterility
- Acupuncture
- Subsequent treatment for venereal disease when those services are available through State and/or local health agencies
- Unkept appointments
- Non-medically necessary items and services provided for the convenience of recipients and/or their families
- Preparation of routine records, forms, and reports
- Visits with persons other than a recipient, such as family members or group care facility staff Refer to 89.III. Adm. Code 140.412 for a complete list of physician non-covered services.

F. Evaluation/Management Services

Office or Other Outpatient Visits

More than one office appointment per day can be billed when medically necessary. When a member has multiple medical appointments on the same day, services of different practitioners, seeing the member in separate sessions and for different conditions or levels of care when medically necessary can be billed.

Multiple Visit Codes during the Same Session

A preventive medicine CPT code and an office or other outpatient evaluation and management CPT code during the same session cannot be billed separately. The practitioner should submit the single evaluation and management service code that best describes the actual services rendered.

Example: a member is seen for a preventive medicine visit and a complaint of a sore throat. Only one evaluation and management service code will be covered.

Therapeutic and Diagnostic Procedures Performed during the Office Visit

When a therapeutic procedure is performed during an office visit, reimbursement is made for the service with the higher State maximum allowable rate, either the visit or the procedure, but not for both.

Exceptions:

- 1. The evaluation and management is an initial visit.
- 2. The patient's condition required a significant, separately identifiable service above and beyond the therapeutic procedure. In such case, the E&M CPT code with modifier 25 must be submitted.
- 3. Insertion, removal, or removal and reinsertion of a long-acting reversible contraceptive (LARC) is separately reimbursable from an evaluation and management service. In such case, the E&M CPT code must be submitted with modifier 25.
- 4. When a diagnostic procedure is performed during an office visit, both the procedure and the visit are separately reimbursable.

New Patient vs. Established Patient Classification

A member may be designated as a "new patient" only once* according to the following MCO-specific timeframes:

мсо	Timeframe
Aetna Better Health	Once every 3 years
ВССНР	Once in a lifetime
CountyCare	Once in a lifetime
Meridian	Once every 3 years
Molina	Once every 3 years

^{*}By an individual practitioner, partner of the practitioner or collectively in a group regardless of the number of practitioners who may eventually see the member.

When a patient is transferred within a group practice setting, a new patient procedure code is not to be used. The visit is classified as for an established patient. Appropriate CPT codes include:

- New patient procedure codes (99201-99205)
- Established patient procedure codes (99211-99215)

Preoperative Visit

When the decision to undergo surgery occurs within a day before the surgery procedure is performed, and the visit includes the preoperative evaluation and management services, the visit is payable. The consult or evaluation and management CPT code should be submitted with the appropriate decision-for-surgery modifier documenting that this visit was not done solely for the purpose of completing the preoperative history and physical.

A visit separate from the decision for surgery visit that is done specifically for the purpose of completing the preoperative history and physical exam is considered part of the surgical package and is not separately reimbursable.

Preventive Services

Certain preventive services are covered for members of all ages. Providers should identify preventive services using the appropriate CPT code(s) or HCPCS code(s), diagnosis codes and, when applicable, modifiers. When the purpose of the visit is preventive in nature, services are rendered on a periodic schedule as dictated by age and risk factors. Services rendered primarily for

preventive purposes should be submitted using the age-appropriate preventive medicine evaluation and management service code.

When preventive services are provided as a part of a problem-focused visit, the office or other outpatient evaluation and management procedure code is to be used instead of the preventive medicine code.

For most preventive services, children are ages birth through 20 years and adults are ages 21 years and older.

Exception: Immunizations. The Vaccines for Children (VFC) program provides free vaccines to enrolled providers for children eligible for all programs ages birth through 18 years. For all other members, providers should bill their usual and customary charge for the vaccine product under the specific vaccine product procedure code.

Preventive Services for Children

Children receive preventive health screening services through the Illinois Early Periodic Screening and Diagnostic Treatment (EPSDT) program. EPSDT services include immunizations, objective developmental screening, dental care, lead screening, vision screening and risk assessments, EPSDT services must be provided in full compliance with applicable federal and State laws and regulations. The Healthy Kids Handbook contains specific information regarding EPSDT services, periodicity schedule, and benefits available to HFS' Medical Program members who are under the age of 21. For more information on Pediatric billing requirements see the Pediatric Services of this billing guide.

Component parts of the well-child screening exam, such as objective developmental screening, risk assessment, immunizations, lead screening, objective hearing and objective vision screening may be billed separately, using the appropriate procedure code(s).

Preventive Services for Adults

Adult preventive services are those services rendered for the prevention or diagnosis of a primary disease, or the prevention of complications of a chronic disease. Covered services include preventive evaluation and management office visits, immunizations for members 21 years and older when administered in accordance with the Center for Disease Control's (CDC) recommended guidelines, screenings for cancer and diagnostic tests and procedures.

One adult preventive medical visit is allowed per year (333 days). One additional preventive medical visit may be allowed within that same time frame when rendered by a new primary care physician (PCP) or for a female annual exam visit.

Providers should bill using the appropriate procedure code for the evaluation and management service. Additional risk assessments, diagnostic tests performed, and immunizations may be billed separately using the appropriate procedure code(s).

Hospital Outpatient Services

Non-Emergency Services

When a practitioner sees a member in the outpatient department of a hospital on a non-emergency basis, for the convenience of either the member or the practitioner, the visit is considered the same as an office visit. If a charge is being submitted for the visit, the appropriate evaluation and management CPT code is to be entered on the billing form. The place of service (POS) must be "11", Office. For POS "11", the claim should be submitted under the rendering practitioner's name and NPI rather than the hospital.

Hospital Observation Care

A practitioner may charge for hospital observation care by using the appropriate CPT codes and in accordance with CPT guidelines. If the member is admitted to the hospital on the same service date as the observation, a charge may be submitted only for the initial inpatient visit. No payment will be made for the observation services. If the member is seen in the emergency room and placed in observation by the same practitioner, a charge may be submitted for the observation care only. Payment is allowed for observation care for consecutive dates of service. Also, only one observation CPT code may be billed. The code for observation care "discharge" is not a covered service.

Payment is not allowed for observation care for obstetrical cases in labor if the member is admitted to the hospital from concurrent observation and delivers the same day.

Hospital Inpatient Services

A practitioner may admit a member for essential inpatient hospital services in connection with covered treatment of an illness or injury. The practitioner should assure that the member meets the established inpatient criteria.

Billing statements submitted for hospital visits are to show the appropriate CPT code designating the level of care provided.

Initial Hospital Care

The admitting practitioner may charge for the initial hospital care of the member only if this has not previously been provided in the practitioner's office or on an outpatient basis prior to the scheduling of the hospital admission. The initial hospital care includes comprehensive history, physical examination, and the initiation of the diagnostic and treatment program. Only the admitting practitioner named on the admission History and Physical reports is eligible for payment for the initial hospital visit for a single hospital stay.

After the day of admission, the attending practitioner may bill one subsequent visit per day. When the member's condition warrants the services of one or more additional practitioners of different specialties, charges are to be submitted as outlined in Concurrent Care below.

Emergency Services

If a member presents at a hospital for emergency care, the hospital's emergency department physician must provide and direct or coordinate the initial service.

Payment for emergency services will be made for either the visit or for specific procedures performed, such as suturing, lavage, application of cast, etc. Payment will be made for the service with the higher State maximum allowable rate. The emergency room practitioner may not submit separate charges for the interpretation of X-rays or EKGs. When the practitioner is assigned to the emergency department, use the appropriate CPT code or evaluation and management CPT code for emergency department services. In this situation, the practitioner must bill using his/her name and NPI. Under no circumstances may the hospital bill the practitioner's service.

Critical Care Services

When a member receives critical care services in the inpatient, outpatient or emergency room setting, the practitioner is to bill using the appropriate critical care evaluation and management CPT codes. Payments will be allowed to one practitioner for a maximum of one and one half (1 %) hours of critical care daily for up to ten (10) days per hospital stay for a single participant.

A practitioner may bill the CPT code for an additional thirty (30) minute increment once per day per patient. A quantity of "1" should be entered in the Days/Units field when billing for this service. Do not use this field to indicate time. The same practitioner may bill for both the first hour and the additional thirty (30) minutes, or two (2) different practitioners may bill the two (2) services. However, payment will be limited to one (1) initial and one (1) subsequent critical care CPT code per day per patient.

Payment is not allowed for postoperative critical care visits by the surgeon for surgical procedures that routinely require critical/intensive care for one or more days. This postoperative period includes the day of surgery and thirty (30) days after surgery.

The critical care visit includes certain services for which separate payment is not allowable on the same day by the same practitioner, e.g., gastric intubation, ventilator management, or the interpretation of diagnostic tests. When the same practitioner performs a procedure outside the all-inclusive list of codes, as well as providing the critical care, payment will be made for the service with the higher state maximum allowable fee.

Concurrent Care

When a participant requires the specialized service(s) of an additional practitioner(s), either concurrently or intermittently during a period of hospitalization, claims can be submitted for the services of both the attending and consultant practitioners. Each practitioner must identify the diagnosis he/she is personally treating.

Long Term Care Facility Visits and Procedures

Charges may be made for a long-term care facility visit and for any procedures performed by the practitioner at the time of the visit in accordance with policy applicable to office services. A

practitioner may submit charges for essential services to a member in the participant's place of residence (i.e., home, long-term care facility, or sheltered care and other custodial facility) when the member is physically unable to go to the practitioner's office.

Newborn Care

Normal newborn care service is considered an inpatient service provided to a newborn who does not develop complications prior to discharge from the hospital. Newborn care includes history and examination of the infant, daily hospital visits, initiation of diagnostic and treatment programs, preparation of hospital records including hospital discharge summary, discussion(s) with the mother and discharge. Providers must follow CPT guidelines to designate the appropriate level of initial and subsequent care of a newborn.

The initial examination and routine follow-up hospital care of the newborn child when rendered by the delivering practitioner is considered a part of the delivery service and may not be billed separately. When a different practitioner assumes care of the newborn, that practitioner may submit charges for the initial and/or subsequent hospital care. A second practitioner may submit charges for attendance at a delivery when required to assume care of the newborn at a cesarean or high-risk vaginal delivery or anticipated high-risk delivery.

See Section VI. Inpatient Hospital, subsection <u>vii Services to Newborns</u> for billing guidance on Newborn claim submission.

Neonatal and Pediatric Intensive Care

Neonatal and pediatric critical care CPT codes are age specific. CPT code identifies procedures considered to be included in the critical care codes. Separate charges should not be submitted for procedures including, but not limited to, endotracheal intubation, lumbar puncture, vascular punctures, blood gas interpretations, ventilation, surfactant administration, etc. Payment is allowed for only one (1) critical care visit code per day, per patient. The initial visit code can only be billed once. Visits made by a second or consulting practitioner must be billed using the appropriate evaluation and management hospital visit CPT codes.

G. Anesthesia

Anesthesia services may be provided by an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) and should be reported according to the Anesthesia Guidelines in the CPT. Anesthesia services are to be billed based on the intraoperative time, anesthesia value of the procedure and physical status of the participant. Medical or surgical procedures performed outside routine anesthesia care may be billed in accordance with the HFS surgical billing guidelines.

The anesthesiologist/CRNA may bill for services when not paid by the hospital or other entity as an employee or independent contractor for this service. Services cannot be billed by both an anesthesiologist and a CRNA for the same procedure on the same participant during a single operative session.

When anesthesia is personally administered by an anesthesiologist who remains immediately available in the operating area during a surgical procedure, the anesthesiologist may submit

charges if the cost of the anesthesiologist's services is not included as an expense item in the hospital reimbursable costs and the hospital submits no_charge for the services. If the anesthesiologist is concurrently responsible for the care of more than one anesthetized patient, a claim may be submitted for each patient involved.

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

Preoperative Period

No charges may be made for the preoperative anesthesia consultation. The reimbursement for these services is part of the anesthesia values assigned to each procedure code.

Intraoperative Period

Anesthesia charges are to be submitted only for the time period spent in the operating room, beginning with the anesthesiologist preparing for induction of anesthesia and ending when the patient may be safely placed under postoperative supervision.

Following are the billing requirements:

- The date of service billed must be the date the anesthesia service begins.
- The procedure code may be either the major surgical procedure code or the anesthesia CPT code, but anesthesia is only paid for one procedure code per surgical session. Effective 10/1/2021, providers must use the appropriate anesthesia code in the CPT code range 00100 through 01999 to bill for the anesthesia units. The major surgical procedure codes will no longer be accepted.
- The physical status modifier (P1 P6) must be the first modifier on the claim.
- Total time for all anesthesia services provided during the surgical session is to be reported in minutes in the Days/Units field.

When surgical procedures are performed during separate operative sessions on the same service date separate charges should be shown for anesthesia administered for each operative session with the anesthesia or major surgery CPT code, physical status modifier, and total administration time for each session.

General Anesthesia

The anesthesiologist/CRNA is to submit one charge totaling the time for all general anesthesia services provided during a single operative session, either the major surgical procedure code or the anesthesia CPT code. Enter the appropriate physical status modifier and the total anesthesia administration time.

Continuous Epidural Anesthesia

The anesthesiologist/CRNA is to submit one charge for the continuous epidural anesthesia services provided during a single operative session using the appropriate anesthesia CPT code. Enter the appropriate physical status modifier and the total anesthesia administration time. Do not submit the major surgical procedure code.

Epidural Anesthesia Followed by General Anesthesia

When epidural anesthesia is followed by general anesthesia on the same date of service during the same operative session, the first charge should be the appropriate epidural anesthesia CPT code with the epidural time in minutes, and the second code should be the appropriate general anesthesia CPT code with the general anesthesia time in minutes.

Anesthesia during Labor and Delivery

Payment is not routinely allowed for the administration of general anesthesia for vaginal deliveries. If general anesthesia is required for vaginal delivery, the CPT code for "unlisted procedure, maternity care and delivery" must be used.

When epidural anesthesia is started during labor and continued through the vaginal delivery or Cesarean section, use the appropriate CPT code(s).

When epidural anesthesia is started during labor but discontinued and then a general anesthetic is administered for the Cesarean section, two charges should be submitted: the first charge should be the appropriate epidural anesthesia CPT code with the epidural time in minutes and the second code should be the appropriate general anesthesia CPT code with the general anesthesia time in minutes.

Postoperative Period

No charges may be made for routine postoperative follow-up care. The reimbursements for these services are part of the anesthesia value assigned to each procedure code.

Payment is allowed for postoperative pain management only for cases of intractable pain, such as that due to multiple trauma injuries or metastatic cancer. Use the appropriate CPT code as well as the appropriate diagnosis code(s) necessitating the anesthesiologist/CRNA services.

Anesthesia Standby

An anesthesiologist/CRNA may submit a charge for "standby" only when the pre-operative anesthetic examination and evaluation have been performed for a planned surgery, but the surgery is canceled due to the participant's condition. The charge should be submitted using the "unlisted" code for the body system/area related to the scheduled surgery. Enter "standby for surgery cancelled due to [specific reason]." Enter the amount of time required for the standby. Standby is not allowed for situations where surgery may or may not be necessary, such as an attempted vaginal delivery that may result in Cesarean delivery, etc.

Anesthesia – Pain Management in an Office Setting

When providing services in an office setting for purposes of pain management (not related to post-operative intractable pain – see above), practitioners **cannot bill** using any of the following taxonomy codes:n

207L00000X - Anesthesiology

207LA0401X – Anesthesiology, Addiction Med

207LC0200X – Anesthesiology, Critical Care

207LP2900X - Anesthesiology, Pain Medicine

These taxonomies are to be used only in conjunction with appropriate anesthesia CPT codes (00100 through 01999). For services performed in an office setting, practitioners must use a physician taxonomy code associated with HFS Category of Service (COS) 001-Physician Services. A taxonomy code look-up tool is available here. Some examples include:

208600000X – Surgery 208D00000X – General Practice Physician 207R00000X – Internal Medicine 208VP0000X – Pain Medicine Physician

H. Surgery

Surgical Services - Office

Certain procedures are eligible for additional reimbursement if the procedure is provided in the practitioner's office. No additional coding is necessary to receive the additional reimbursement. Additional information regarding the surgical add-on may be found on the Practitioner Fee Schedule.

Anesthesia

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

Burn Treatment

Charges may be made for surgical debridement for burns, when substantiating information is submitted. The appropriate CPT code is to be used to submit charges for surgical debridement. No additional charge may be made for the evaluation and management CPT code.

Surgical Services - Hospital

Covered Surgical Procedures

Surgical procedures are allowable when they are medically necessary, recognized as standard medical care and required for the immediate health and well-being because of illness, disability, infirmity, or impairment.

Global Postoperative Period

Reimbursement for a major operative procedure includes the pre-surgical examination subsequent to the decision for surgery and rendered on the date of surgery or the day immediately prior, and complete postoperative care including postoperative office visits and customary wound dressings for a period of 30 days. Reimbursement for a burn procedure (debridement, skin grafting, and/or flaps, etc.) includes postoperative visits, wound care, and dressing changes for a period of seven (7) days after the surgical procedure.

Concurrent Care during Postoperative Period

A practitioner other than the surgeon may receive reimbursement during the postoperative period only for visits for conditions/diagnoses unrelated to the surgery.

Multiple/Complex Procedures

Instructions for billing multiples are specific to the procedure code and are included in the Practitioner Fee Schedule. Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package. Surgical procedures considered incidental to or a component of the major procedure will not be paid separately from the major code.

Co-Surgeon/Surgical Assistance

Co-Surgeon

When two surgeons of equal competence participate in an operation on a basis of other than surgeon and assistant surgeon, payment is based upon the procedure(s) accomplished and will be divided equally between the two surgeons. Procedure codes payable to co-surgeon are identified on the Practitioner Fee Schedule. Enter the appropriate procedure code(s) for the specific surgical procedure(s).

Surgical Assistance

Surgical assistance is a covered service only when provided for major or complex surgical procedures. Procedure codes payable for surgical assistance are identified on the Practitioner Fee Schedule. Enter the appropriate procedure code for the major surgical procedure. Enter the appropriate assistant-at-surgery modifier in the Modifier Field. Complete the "Days/Units" Field of the service section showing the time required to assist at the surgery. Enter the actual time in minute format, e.g., the entry for 1 hour and 10 minutes is "0070."

Surgical assistance by a non-enrolled APN

Charges for assistant surgeon services rendered by a non-enrolled APN* must be submitted under the surgeon's name and NPI. Enter the appropriate procedure code for the major surgical procedure. Enter modifier "AS" in the Modifier Field. Complete the "Days/Units" Field of the service section showing the time required to assist at the surgery. Enter the actual time in minute format, e.g., the entry for 1 hour and 10 minutes is "0070."

* NOTE: Effective September 1, 2021, APNs will be required to enroll in IMPACT and bill using their own NPI. Claims using the AS modifier and billed under the surgeon's name will not be accepted.

Surgical Burn Treatment

Practitioners may submit charges for surgical burn treatment, including debridement, participant site preparation, and application of skin replacements or substitutes (grafting). An evaluation and management visit on the same day as the surgical burn treatment by the same practitioner is not reimbursable. Claims must be submitted using the appropriate CPT code for the location and type of wound preparation and application of grafts. The CPT code for the initial procedure is billed with

Days/Units showing quantity "1." The subsequent service section should contain the CPT add-on code for all additional square cm or percent body area, with the total additional quantity shown in the Description Field, and with the Days/Units Field showing quantity "1."

I. Family Planning, Pregnancy/Maternity Care and Reproductive Health Care Family Planning Services

Family planning services are designed to prevent unintended pregnancies and to improve reproductive health and birth outcomes. Services and supplies that are specifically provided for the purpose of family planning are covered, regardless of gender or marital status. Family planning does not apply to a participant who has been sterilized or is pregnant. Claims for family planning services should include the appropriate **CPT code with Modifier FP** (services provided as part of family planning program) and the appropriate diagnosis code that documents the family planning service provided. The following services are covered:

- Medical history and reproductive health exam
- Preconception care risk assessment
- Diagnostics (e.g., laboratory, bone scan, ultrasound tests) necessary for the provision of contraception or sterilization
- Contraception
- All FDA-approved methods, including Emergency Contraception
- Sterilization procedures
- Tubal ligation
- Vasectomy

Immediate Postpartum LARC Insertion

Practitioners not salaried by the hospital may bill the appropriate CPT code for the LARC insertion in addition to their delivery charges.

Sterilization

When a tubal ligation is performed following a vaginal delivery or a Cesarean section, payment will be made for the tubal ligation in addition to the delivery.

When the sterilization is performed in a hospital by a salaried hospital staff physician, the signed form HFS 2189 is to be attached to the UB-04. See IAMHP memo for assistance in completing HFS 2189, located in Appendix F of this manual.

Performance of a procedure that renders a participant sterile, but that was not performed with the intent to sterilize the participant (e.g., removal of a portion of a fallopian tube due to an ectopic pregnancy), must be submitted with the appropriate surgical CPT code and Acute Treatment modifier "AT."

Procedure with Visit

Payment for an annual preventive, problem focused E/M visit, or postpartum visit and a long-acting reversible contraceptive (LARC) insertion or removal procedure is allowable when modifier 25 is appended to the E/M service. See below for examples:

When the provider and the patient:

- Discuss contraceptive options during an initial or annual preventive visit (99381-99397) or a postpartum visit, and subsequently during the same visit the device is placed, a service code with modifier 25 in addition to the insertion procedure code is reimbursable.
- Discuss contraceptives during a problem focused E/M visit (99201-99215) that was initiated for a reason other than LARC insertion, and on the same date of service the provider places the device, a problem focused E/M service code with modifier 25 in addition to the insertion procedure is reimbursable.
- Review a previously chosen LARC method and proceed with placement of the LARC, only the insertion procedure code may be submitted.

Providers must use the appropriate Z30 series from the ICD-10 for the primary code attached to the insertion (and/or removal) procedure code.

Reproductive Health Services

The following reproductive health-related services are covered:

- Medical history and reproductive health exam
- Cervical cancer screening, abnormal Pap follow-up (such as repeat Pap tests, colposcopy/biopsy, LEEP, CONE), and HPV vaccination
- Testing and treatment for STIs found during the family planning exam, and required follow-up
- Testing and medications for UTI, vaginal, other lower genital tract and genital skin infections found during the family planning exam, and required follow-up
- HIV testing
- Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy
- Hysterectomy

Reproductive health services should be billed with the appropriate procedure and diagnosis codes for the services provided.

Hysterectomy

A hysterectomy is a covered service only when, in the practitioner's professional judgment, it is not performed solely to accomplish sterilization, but is done for other medical reasons. If there is more than one purpose to the procedure, the practitioner 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. The participant:

Was already sterile at the time of the hysterectomy

- Had the hysterectomy under a life-threatening emergency in which prior acknowledgment of receipt of hysterectomy information was not possible
- Had a hysterectomy performed during a period of retroactive eligibility, and the participant
 was advised that the operation would render her permanently incapable of reproducing, or
 the exceptions described above made such an explanation unnecessary or impossible.

When the procedure is a covered service, payment for the services provided will be made only when the claim is accompanied by the signed documentation as evidence that the individual or her representative has been informed orally and in writing prior to the surgery that the procedure will render the individual permanently incapable of reproducing. Written consent to perform a hysterectomy must be obtained on the Acknowledgement of Receipt of Hysterectomy Information, HFS 1977. For assistance in completing HFS 1977 see IAMHP memo located in Appendix F.

Exception: The participant's (or representative's) signature is not required if one of the exception statements on <u>form HFS 1977</u> has been completed by the practitioner. Use the appropriate CPT code, which describes the procedure performed. A copy of the completed HFS 1977 must be attached to the claim.

Pregnancy/Maternity Care

Practitioners may submit an evaluation and management CPT or a Category II CPT code for antepartum care for the initial visit to determine pregnancy.

Prenatal Care

The appropriate CPT code for the initial prenatal visit is to be reported on the first prenatal encounter with the health care professional providing obstetrical care. Reporting of the last date of menstrual period (LMP) must be reported when billing for the initial prenatal CPT code. For perinatal depression services, refer to the <u>Pediatric Services</u> of this billing guide.

Subsequent prenatal office visits are to be billed using the appropriate Category II CPT codes for antepartum care.

Visits for Medical Complications of Pregnancy

Emergency room or inpatient hospital visits for complications of pregnancy or other diagnosis/conditions related to pregnancy should be billed separately using the appropriate visit codes and not the prenatal visit code. The diagnosis code(s) shown on the claim must be pertinent to the condition(s), which necessitated the hospital visit(s). Providers should bill the day of hospital admission using the appropriate "subsequent" visit code when the admitting practitioner has also been providing prenatal care.

Treatment to Prevent Premature Delivery

Claims can be submitted for the following:

• Injection of Alpha Hydroxyprogesterone (17P). Providers will be reimbursed to administer one dose per week during weeks 16 through 36 of the pregnancy. Administering practitioners who purchase the product from a 17P compounding pharmacy may bill for the product, in addition to the administration. 17P should be restricted to pregnant women with a single gestation and a history of prior spontaneous preterm delivery.

 Home uterine monitoring in cases where the woman has been hospitalized and is being discharged on tocolytic drugs. An all-inclusive daily rate is paid directly to the supplier of the monitoring device.

Visits for Medical Conditions not related to Pregnancy

Medical office visits that occur during the prenatal period for conditions other than pregnancy should be billed using the appropriate office visit procedure code for the level of service provided.

Delivery

Use the appropriate CPT code for either vaginal delivery or Cesarean Section to bill the delivery. All maternity care services must be billed with separate codes, dates, and charges. An all-inclusive "global" care package will not be reimbursed.

Payment for delivery includes admission to the hospital, the admission history and physical, management of labor, vaginal or cesarean delivery, and post-partum hospital care.

Procedure for billing multiple births:

Enter the appropriate delivery CPT code for the first baby and the unlisted procedure code for all additional babies when billing for multiple births. Enter the description "twin, triplet, etc." in the description section and a separate charge for each delivery. If one baby is delivered vaginally and the other by Cesarean section, bill the correct code for each with separate charges, and attach both delivery reports.

Payment may also be made for a vaginal delivery that the practitioner performs in the participant's home. The appropriate vaginal delivery CPT code is to be used and Place of Service (POS) – 12 home.

Payment is allowed for initiation and/or supervision of internal fetal monitoring during labor only when performed by a consulting practitioner. This service must be billed with a diagnosis code(s), which reflects medical necessity, e.g., high-risk pregnancy.

For information regarding deliveries at Birthing Centers, refer to <u>Birthing Center</u> section of this billing guide.

Postpartum

A charge may be submitted for only one (1) six-week postpartum visit per patient, per delivery. Additional visits for postoperative wound checks or outside the six-week postpartum period must be billed with the appropriate evaluation and management CPT code.

J. Radiology Services

Radiological and X-ray services are covered when essential for the diagnosis and treatment of disease or injury. Routine screening X-rays are not covered. **Exception** is mammography.

Charges for the professional or technical component of radiology services must be submitted with the appropriate CPT code and modifier. Additional information regarding billing for radiology services or multiple occurrences of the same procedure on the same date of service may be found on the <u>Practitioner Fee Schedule Key</u>.

Certain X-rays are limited to a quantity of one (1) per day due to the nature of service, e.g., angiography, gallbladder, upper GI series, etc. If the procedure is repeated at a separate time on the same day, the "unlisted" code is to be used with a separate charge.

A practitioner may charge only for X-ray examinations provided in the practitioner's own office, by the practitioner's staff. When only X-rays are provided at the time of an office visit, an office visit charge may not be made. A central X-ray Department serving the practitioners in group practice is considered the practitioner's office.

Hospital-Based Radiology Services

Only a non-salaried radiologist may bill for the professional component. A hospital- based radiologist may submit charges for professional services in connection with referred X-ray services if the radiologist's contractual agreement with the hospital provides for separation of charges and is not included in the cost report for direct patient care. The services must be billed using the hospital-based radiologist's NPI and not the hospital NPI for the professional component. Any interpretations of X-rays or tests not directly related to patient care are not reimbursable.

Radiation Therapy

A radiologist may charge only for the specific X-ray examinations or radiation therapy provided in accordance with requests of the referring practitioner. Additional charges for visits or services, such as dosage calculations, port plans, field settings, etc., are not reimbursable.

Proton Therapy

Proton therapy is reimbursable to facilities having a 'PTN' specialty code on file. Reimbursement is allowed for one proton beam treatment delivery code per date of service. In addition, one radiation treatment delivery code is separately payable for the purpose of guidance/localization of the proton beam.

Ultrasound Imaging

Ultrasound imaging, scanning, echograms, or sonograms are covered when medically necessary. Routine screening or surveys are not allowed, nor are "rule-out" examinations unless a specific differential problem exists.

When a charge is made for ultrasound examinations, an additional charge cannot be made for radiographic examinations of the same area or systems unless adequate justification is given for both procedures.

Surgical/Diagnostic Procedures Requiring Radiological Supervision/Interpretation

When a radiologist performs a specific procedure, e.g., catheter insertion, biopsy, injection, angioplasty and radiological supervision and interpretation, two separate codes and charges should be submitted.

The charges for the procedure and the radiological supervision/interpretation are to be shown on the same claim with Type of Service Code "4, diagnostic X-ray – radiologist." If the procedure is performed percutaneously and no specific code is available, the practitioner is to use the unlisted code for the pertinent body system and the specific procedure identified in the description field.

Radiologists are not to use incisional procedure codes for procedures done percutaneously.

Computer Tomography (CT) and Magnetic Resonance Imaging (MRI)

Reimbursement may be made to the practitioner for interpretation of CT or MRI procedures provided in any setting. Payment is allowed for only one complete CT or MRI procedure per day per patient (e.g., a CT of the abdomen and pelvis is a complete procedure or multiple sections of the spine).

Multiple Radiology Procedures on the Same Day

Multiple radiology procedures performed on the same day involving areas of the body that are overlapping are either paid at a reduced rate or rejected as an X-ray procedure previously paid. This methodology applies to all radiological testing including X-rays, CT/CTA's and MRI/MRA's.

Examples of overlapping radiological studies include:

- Radiological exam of the pelvis, 1 or 2 views, combined with radiological exam of the hip, complete, minimum 2 views
- CT of the abdomen and CT of the pelvis, or CT of the head and CT of the neck
- Any CTA in combination with any CT
- MRI of multiple levels of the spine
- Any MRA in combination with any MRI

Mammography Screening

Mammography screening is a covered service when ordered by a practitioner for screening by low-dose mammography for the presence of occult breast cancer. Coverage for this service is available under the following guidelines:

- Baseline mammogram for women 35 and older
- Screening mammogram once per year for women 40 years of age or older

A mammogram for diagnostic purposes is covered when medically necessary, regardless of sex or age.

K. Laboratory

Laboratory Tests

Only those laboratory tests and examinations essential for diagnosis and evaluation of 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. There is a maximum amount payable for certain panels and chemistries. Refer to <u>Practitioner Fee Schedule Key and Lab Rates</u>.

Practitioner Laboratory Billing

A practitioner may charge only for those tests performed in the practitioner's office by the practitioner's salaried staff. Claims for laboratory tests performed in the practitioner's office includes both the professional and technical component fees. A practitioner may not charge for laboratory tests when a specimen is obtained but sent out of the office, e.g., skin lesions, pap smears, etc.

A central laboratory, serving practitioners in group practice, is considered a practitioner's office laboratory. When the participant presents for laboratory tests only, an office visit charge may not be submitted.

Ordered or Referred Laboratory Billing

For necessary laboratory tests not provided in the practitioner's office, the practitioner is to refer the participant to 1) the outpatient department of a participating hospital, 2) a pathologist in private practice, or 3) a Medicare certified independent laboratory.

The practitioner must include the participant's diagnosis or presenting symptoms that indicate the need for the specific tests ordered. The practitioner's NPI must be available to each laboratory to which referrals are made.

The practitioner may not charge for making a referral, for collection or sending of a specimen for analysis or for tests ordered. The actual provider of services is to submit charges directly. A charge may be made for a Pap smear only if the laboratory examination is performed in the practitioner's own office laboratory.

A pathologist in private practice may charge for the specific tests and examinations provided; however, an additional office visit charge may not be made. If the pathologist has an office laboratory certified by Medicare as an independent laboratory, independent laboratory policy and procedure apply

A hospital salaried pathologist may submit charges for professional services in conjunction with referred laboratory services only if the pathologist's contractual agreement with the hospital provides for separation of charges. The claim should be billed using the salaried pathologist's NPI and not the hospital's NPI for the professional component.

Charges for the professional or technical component of laboratory services must be submitted with appropriate CPT code and modifier. Additional information regarding billing for laboratory services or multiple occurrences of the same procedure on the same date of service may be found on the Practitioner Fee Schedule Key.

Organ or Disease Oriented Panels

CPT codes for panels should be used to report "organ panels", e.g., Hepatic Function Panel, Thyroid Panel, Arthritis Panel, or profiles that combine tests under a problem-oriented classification such as Obstetric Profile and Lipid Profile. Providers should not submit charges for individual components of the panel.

Chemistries

When not all the tests in the panel are performed, individual test CPT codes are to be used and a separate charge shown for each code. Individual chemistries that are not part of a panel may be billed.

Drug Testing

Measurement of one or more drugs in body fluids and/or excreta may be billed under the specific procedure code for the drug(s) test. If no specific drug code exists, the unlisted drug assay CPT code is to be used.

B12 Testing

Payment is allowable for Vitamin B12/Folic Acid testing only when the possibility of Vitamin B12 deficiency is indicated after the presence of macrocytic anemia is detected by a complete blood count.

Blood Lead Screening

Claims can be submitted by practitioners for blood lead screening as follows:

- Practitioners enrolled to provide Healthy Kids services who have requisite equipment may bill
 for the Clinical Laboratory Improvement Act (CLIA) waived blood lead analysis [ESA Biosciences
 LeadCare II Blood Lead Testing System (Whole Blood)] using the appropriate CPT code. The
 venous or capillary blood lead draw is not to be billed separately.
- Practitioners enrolled to provide Healthy Kids services who send blood lead specimens to the
 Illinois Department of Public Health (IDPH) laboratory for analysis may bill for venous or
 capillary blood lead draw using the appropriate CPT code and the State-specified modifier.
 Laboratory analysis for lead screening is conducted by the Illinois Department of Public Health
 and must be mailed to the following address:

Illinois Department of Public Health Division of Laboratories 825 North Rutledge, P.O. Box 19435 Springfield, IL 62794-9435

• For additional Pediatric billing guidance see the <u>Pediatric Services</u> of this billing guide.

Pap Tests and Prostate-Specific Antigen Tests

Coverage is provided for the following:

- An annual cervical smear or Pap smear test for women.
- An annual digital rectal examination and a prostate-specific antigen (PSA) test upon the recommendation of a practitioner for:
 - Asymptomatic men age 50 and older;
 - African American men age 40 and older; and
 - Men age 40 and older with a family history of prostate cancer.

Reimbursement for a pelvic exam to obtain the Pap smear or the digital rectal examination is included in payment of the appropriate evaluation and management CPT code. Payment for the Pap or PSA is reimbursable to the performing laboratory.

L. Vaccinations (Immunizations)

Vaccinations (immunizations) are covered for children based on schedules established by the Advisory Committee on Immunization Practices (ACIP). Vaccinations are covered for adults when the provider has determined the vaccine to be medically necessary and for preventive purposes (such as influenza and pneumonia vaccines) when administered in accordance with the Center for Disease Control's recommended guidelines.

For information on billing vaccinations for children, refer to the <u>Pediatric Services</u> section of this manual.

For adult vaccinations, 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 may be submitted to cover the injection service expense. The specific vaccine product procedure code is to be submitted to cover the cost of the vaccine or the cost of obtaining it through VFC. Seasonal flu vaccinations follow these guidelines.

M. Psychiatry

227.1 Individual Psychiatric and Psychotherapy Services

Individual psychiatric and individual psychotherapy services may be covered when personally rendered by an enrolled physician, an enrolled Advanced Practice Nurse (APN) who holds a current certification in Psychiatric and Mental Health Nursing as set forth in 68 Ill. Adm. Code 1300, Appendix A and is practicing in accordance with the Nurse Practice Act, a Licensed Clinical Psychologist (LCP) or a Licensed Clinical Social Worker (LCSW).

Services provided by individual Licensed Clinical Professional Counselors (LCPCs), or Licensed Marriage and Family Therapists (LMFTs) are not reimbursable. LCPC and LMFT services are only reimbursable when rendered in community mental health centers or Encounter Rate Clinics enrolled to provide those services. Such services must be provided and billed in accordance with guidelines in the applicable handbooks:

- Community Based Behavioral Services for CMHCs.
- Handbook for Encounter Rate Clinics.

Psychiatric services are covered only when the participant is present for all or some of the service. Psychotherapy times are for face-to-face services with the patient. Psychotherapy of less than 16 minutes duration should not be billed.

Psychiatric diagnostic procedures are stand-alone services and are not to be submitted in combination with evaluation and management service codes, nor may they be submitted on the

same day as psychotherapy services. An evaluation and management service may be separately payable with a psychotherapy service.

A psychiatric service may not be billed when the participant receives a psychotropic drug injection and no other service is performed; however, a minimal office visit may be submitted along with an additional charge for the cost of the psychotropic drug when administered in the practitioner's office.

The participant's record is to show the actual time spent in direct patient care, not including the time required for documenting the record, making reports, etc.

Psychiatric Services Rendered by a Physician or APN

Payment will be allowed for only one psychiatric service to a participant per day when rendered by a physician or APN. This limitation does not apply when psychiatric services are rendered by a physician or APN on the same day that psychotropic medication monitoring is rendered at a Community Mental Health Center (CMHC). Electroconvulsive Therapy (ECT) is not considered a psychiatric visit and is not affected by this service limitation.

Psychiatric Services Rendered by a LCP, LCPC or LCSW

Certain services rendered by LCPs, LCPCs, and LCSWs are reimbursable. This applies to services rendered by individual LCPs, LCPCs, and LCSWs practicing outside a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Encounter Rate Clinic (ERC), or Rural Health Center (RHC).

Self-administered and self-scored tests of cognitive function, biofeedback therapy, and services identified in 89 III. Adm. Code 140.6 are not eligible for reimbursement.

Refer to the <u>Fee Schedule for Licensed Clinical Psychologists and Licensed Clinical Social Workers</u> for covered services and reimbursement rates.

When psychiatric services are rendered by a LCP, LCPC, or LCSW, payment will be allowed per participant per day as follows:

- One psychiatric evaluation service per day;
- A maximum of two units of psychotherapy per day; and,
- One unit of psychotherapy for crisis per day.

Inpatient Care

Basic daily inpatient psychiatric care consists of a therapeutic encounter with the participant and must include one of the following services or an equivalent:

- Medical psychotherapy that may include but is not limited to psychoanalysis; insight-oriented therapy; behavior modification; supportive therapy.
- Continuing medical/psychiatric diagnostic evaluation.
- Psychotropic drug management.

- Supervision and management of the patient's treatment program which may include providing guidance and direction to hospital employees involved in the patient's treatment program and/or participation in conferences to plan treatment program.
- Communication with significant others to facilitate patient compliance with hospital treatment and after care.

N. End Stage Renal Disease (ESRD) Treatment

Reimbursement for continuing medical management of a maintenance dialysis participant may be made to a practitioner. The services covered by the payment must be in accordance with Medicare ESRD guidelines and billed following the appropriate CPT guidelines. Charges for the insertion of grafts, shunts, de-clotting of shunts, and non-renal physician services are not considered part of dialysis management and must be billed separately.

If an ESRD participant is temporarily transferred to another practitioner for services covered by the monthly payment, charges are not to be submitted by the attending practitioner for the days that the participant is in the transferred status. Each practitioner may only submit charges for the services rendered.

Non-Medicare Eligible Participant

Monthly

The appropriate CPT code for End Stage Renal Disease Related Services is to be used when services are provided during a full month (one procedure code and one charge). **The last day of the month** covered by the monthly payments is to be shown as the date of service. Allow a minimum of 27 days to pass before billing the next month.

Daily

The appropriate CPT code for End Stage Renal Disease Related Services **per day** is to be used when services are not performed consecutively during an entire full month (i.e., patient is a hospital inpatient during the month or services are initiated after the first or the care is transferred to a different practitioner for part of the month). Separate entries with the appropriate date of service must be made for each daily charge submitted.

Charges for daily medical management services are not to be submitted for a date of service on which 1) the practitioner has submitted a charge for non-renal services; 2) the patient was under the care of another practitioner (i.e., temporarily transferred); 3) a charge was submitted for services excluded from the monthly payment; or 4) the practitioner has billed as a concurrent care practitioner.

O. Pulmonary Services

Essential pulmonary tests and procedures provided by a practitioner are covered when medically necessary.

Pulmonary services with an Office Visit

When pulmonary tests and/or procedures are performed but the practitioner does not see the participant, an office visit charge may not be made. Visits are not separately payable along with pulmonary services with the following exceptions:

- The evaluation and management is an initial visit.
- The patient's condition required a significant, separately identifiable service above and beyond the pulmonary service. In such a case, the evaluation and management CPT code with modifier 25 must be submitted.

Ventilation Management

Ventilation management is a covered service when provided to a participant in the inpatient hospital and nursing home settings.

In accordance with CPT guidelines, the practitioner who is responsible for the ventilation management of a participant may submit charges for either the ventilation management or evaluation and management, but not both on the same day. Another provider may charge for a visit for an unrelated diagnosis.

Ventilation management, initial or subsequent, is not billable by the anesthesiologist for the day anesthesia is administered for surgery. The provision of adequate ventilation to a participant is included in the anesthesia administration fee. When care is rendered in the two days immediately preceding or in the two days immediately following a surgical procedure, by the same practitioner who provides the surgical anesthesia, the services are also considered as part of the anesthesia services related to the surgery and separate charges may not be made for therapy.

P. Allergy Services

Allergy sensitivity tests and desensitization services (immunotherapy) provided by a practitioner are covered when medically necessary.

Testing

The initial office visit for allergy investigation is considered a comprehensive diagnostic office visit. Appropriate skin tests, sputum and nasal secretion studies and other essential services are separately billable.

CPT codes listed under Allergy Testing should be submitted for allergy sensitivity tests. The specific number of tests performed should be entered into the days/units field up to the maximum quantity as specified on the Practitioner Fee Schedule.

Desensitization Injections (Immunotherapy)

Separate coding for each service should be submitted. Billing instructions specific to each code may be found on the Practitioner Fee Schedule.

Allergenic extract preparation and provision only

The practitioner, who prepares or supervises preparation of the extract, should submit charges for the extract. Charges should be submitted for the total number of doses or vials as specified by the CPT code.

Injection service only

The practitioner who renders the injection service should submit charges for professional services not including provision of allergenic extracts, for single or multiple injections as specified by the CPT code.

Allergenic extract preparation, provision, and injection service

The practitioner who prepares or supervises preparation of the extract and provides the injection service should submit charges for each service under its separate code. Allergenic extract should only be billed when each new vial of antigen is prepared.

Allergy services with an office visit

Visits are not separately payable along with immunotherapy services with the following exceptions:

- The evaluation and management is an initial visit.
- The patient's condition required a significant, separately identifiable service above and beyond the immunotherapy service. In such a case the evaluation and management CPT code with modifier 25 must be submitted.

Q. Practitioner Administered Drugs including Chemotherapy

Reimbursement for certain practitioner-administered drugs may be made to practitioners. The drug must have been purchased by the practitioner and must be administered in the office setting in order to be submitted on the professional claim. Medications charged through a pharmacy or facility are not billable.

Submit the appropriate CPT or HCPCS Code(s) to identify the drug. When a specific code is not available, an unlisted medication CPT code may be used. The corresponding description field must contain the name of the drug, strength of the drug and amount given. Quantities must be billed according to the Instructions for Billing Multiples located in the Practitioner Fee Schedule Key.

While coverage for injectable drugs is considered separately from visits or injection administration, the injection procedures themselves (such as tendon or trigger point injections) are considered therapeutic procedures and reimbursement will be made for either the visit or the procedure.

Exceptions include:

- The evaluation and management is an initial visit.
- The patient's condition required a significant, separately identifiable service above and beyond the therapeutic procedure. In such case, the E&M CPT code with modifier 25 must be submitted.

Prior Approval Requirements for Practitioner Administered Drugs

The HCPCS Codes for practitioner-administered drugs that require prior approval are noted on the Practitioner Fee Schedule. Prior authorization may be required by the MCOs. Link here for information on the MCO's authorization requirements.

Chemotherapy Services

Chemotherapy services may include provision of chemotherapy administration, chemotherapeutic agents, non-chemotherapeutic drugs, use of supplies and additional evaluation and management services. Not all services are separately billable. Link here for more information on Pharmacy billing requirements.

Chemotherapy Administration

Payment for chemotherapy administration in the office setting may be made to physicians, APNs, and PAs.

The initial hour and subsequent/concurrent time are to be billed according to the CPT guidelines for chemotherapy administration. No payment is made for venous or arterial puncture performed for the purpose of administering the chemotherapy.

Drug Charges

Practitioners may submit separate charges for the chemotherapy agents and for non-chemotherapy drugs associated with the chemotherapy. The drugs are payable to practitioners in the office setting only. Drugs used in the administration of the chemotherapy should not be billed through the Pharmacy Program.

Chemotherapy Drugs

When billing for chemotherapy drugs, use the appropriate HCPCS Codes, indicating the quantity and the corresponding NDCs.

Non-chemotherapy Drugs

Coverage for non-chemotherapy drugs administered for cancer-related treatment or conditions caused by the effects associated with the chemotherapy is reimbursable on chemotherapy or non-chemotherapy days. Claims must contain a chemotherapy diagnosis. Use the appropriate HCPCS Codes, indicating the quantity and the corresponding NDCs.

Chemotherapy Supplies

Supplies, including fluid used to administer the drugs and to flush infusion ports or lines, are considered incidental according to the CPT guidelines and are not reimbursed separately.

Chemotherapy Services with an Office Visit:

Visits are not separately billable along with chemotherapy administration.

Exceptions include:

The evaluation and management is an initial visit.

 The patient's condition required a significant, separately identifiable service above and beyond the therapeutic procedure. In such case, bill the E&M CPT code with modifier 25.

R. Special Services

Conscious (Moderate) Sedation

When billing for conscious sedation, the CPT guidelines are to be followed. The same practitioner performing the diagnostic or therapeutic service may bill separately for conscious sedation provided only when the CPT code itself does not include conscious sedation.

Conscious sedation provided by a second practitioner (other than the practitioner performing the diagnostic or therapeutic service) may be billed when **all** the following conditions are met:

- Services of a second practitioner are required;
- Services are personally rendered by the practitioner billing for the sedation; and
- The practitioner is non-salaried, enrolled with Medicaid, and billing under his/her individual NPI.

Unusual Travel

A practitioner may submit charges for travel if it is medically necessary that the practitioner personally accompanies a participant who is being transported, e.g., by ambulance or air from one hospital to another.

Mileage

When it is the practitioner's usual and customary practice to charge for mileage to see patients at their places of residence, charges may be made for mileage from the city limits of the town in which the practitioner practices to the place of residence, unless subsequently specified otherwise. Only one mileage charge may be made regardless of the number of participants seen at the time of the home visit.

Procedure code 99082 is to be used to identify charges for mileage. The total number of miles one way must be specified in the Days/Units field. The destination, e.g., long term care facility, etc., is to be entered in the facility field. Practitioners who derive direct or indirect profit from total or partial ownership of where the participant resides may not charge for mileage.

S. Pharmacy/Medical Equipment/Medical Supplies

When the practitioner determines that an individual has a medical need for a pharmacy item, medical equipment or supplies, a prescription or an order must be written. If the item requires prior approval, the dispensing provider will be required to obtain prior approval from the MCO. Providers will need to submit a medical or prescription order with the prior approval.

Medical Equipment and Supplies Dispensed in a Practitioner's Office

Reimbursement for medical supplies (i.e., rubber gloves, colostomy supplies, tracheotomy supplies) dispensed by a practitioner that are not durable or reusable is not allowed. Coverage is limited to

those items that are required following a treatment plan for a specific medical condition. Medical supplies are not to be dispensed or prescribed for a participant's personal convenience.

Exception: Charges may be submitted for items normally available in a practitioner's office (i.e., crutches, wrist splints, air cast, knee brace).

The HCPCs of the specific hand-priced item must be billed and a copy of the invoice showing the actual cost must be attached to the claim.

XXVIII. Physical, Occupational and Speech Therapy Services

A. Section Purpose

The purpose of this section is to outline policies and procedures for providers billing for therapy services (physical, occupational and speech).

B. Provider Type Description

Therapy service providers must meet one of the following criteria:

- A physical therapist (PT) who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice
- An occupational therapist (OT) who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice
- A speech-language pathologist (SLP) who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for licensure.

Therapy providers must be registered in the IMPACT system according to the table below.:

IMPACT Provider Type Code	Provider Type Description	Category of Service
22	Physical Therapists	11, 41, 48
23	Occupational Therapists	12, 41, 48
24	Speech Therapists	13, 41, 48

- An enrolled therapist may only charge for services he or she personally provides, or for services provided by a licensed therapy assistant under the supervision of the enrolled therapist.
- Speech-language pathologists may also charge for services provided by individuals in their Clinical Fellowship year.
- **NOTE:** COS 41 and 48 is for Early Intervention billing only. Therapists should NOT be billing DME items/supplies to MCOs. Hospitals may bill for salaried therapists using the hospital's NPI through the Institutional format. (see Hospital Outpatient billing section of this guide)
- Providers may not charge for services provided by another provider, even though one may be in the employ of the other.
- Services must be billed in accordance with the Therapy Providers Fee Schedule.

Any claims that do not require attachments or have accompanying documentation may be billed using the CMS1500 or 837P claim format.

NOTE: Effective July 1, 2020, hospitals (Provider Types 30, 31 or 32) must bill therapy services using the UB-04 or 837I institutional claim format. See <u>Outpatient Hospital billing guidance</u> for details. Physical, occupational and speech therapy services should be billed with the actual therapy codes. Hospitals must use the appropriate revenue code and complete the associated fields. **Therapy services provided by hospitals will no longer be cross-walked to a smaller subset of covered codes.**

C. Coding Guidance

The HFS therapy fee schedule and instructions apply to the following providers:

- Physical, Occupational, and Speech therapists' billing under their individual NPIs.
- Certified Health Departments and Community Health Agencies billing for salaried/hourly Physical, Occupational, and Speech Therapists providing services on site with their agency NPI.

Required Elements for a Therapy Claim

Fee Schedule Item	Description
Procedure Code	CPT Code - Must be on the HFS Fee Schedule and be cross-walked to HFS' coding guidance (table below)
Modifiers	GN: Required when billing Speech Therapy services GO: Required when billing Occupational Therapy services GP: Required when billing Physical Therapy services
Max Quantity	The maximum number of units billable for the procedure code. A Max Qty greater than '1' indicates the code is billable in 15-min increments. In these instances, 1 unit = one 15-min increment.

For all providers EXCEPT hospitals, therapy codes must be cross-walked according to the table in the <u>HFS Fee Schedule</u> under the crosswalk tab. MCOs require the use of the cross-walked code.

D. Services

Covered Services

Covered therapy services include medically necessary evaluations and treatment by a licensed therapist when:

- services are required because an illness, disability or infirmity limits functional performance;
 and
- ii. speech therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when therapy services will increase independence and/or decrease need for other support services. Services must be provided in accordance with a definite plan of care established by the therapist or clinical fellow, for the purpose of attaining maximum reduction of a physical disability and restoration of the participant to an acceptable functional level.

Non-Covered Services

Therapy is for the purpose of attaining reduction of a physical disability and/or restoration of the individual to an acceptable functional level. Services provided for the general good and welfare of

participants, such as fitness exercises and activities to provide diversion or general motivation, and maintenance therapy to maintain the current level of function, are not covered.

Prior Authorization Process

Prior Authorization is required for all therapy services, with the exception of the evaluation codes . If charges are submitted for services that require prior authorization and it was not obtained, payment will not be made for services as billed. See Prior Authorization section for further information on individual MCO prior authorization information.

XXIX. Ambulatory Surgical Treatment Centers (ASTCs)

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Ambulatory Surgical Treatment Centers (ASTCs).

B. Provider Type

The ASTC section applies to Provider Type 046 – ASTC.

C. IMPACT Enrollment Requirements

The provider must be a registered provider of ASTC services in the HFS IMPACT system with a specialty of Ambulatory Surgical Treatment Center and a sub-specialty of Outpatient Surgery.

D. Billing Requirements

Covered Services

Facility Services

Facility services furnished by an ASTC include, but are not limited to:

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

ASTCs shall not provide beds or other accommodations for the overnight stay of patients. However, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients up to 23 hours following admission.

Supplies and equipment used by the ASTC for the diagnosis or treatment of the patient during the ASTC surgical visit are included in the ASTC's all-inclusive visit/rate. Drugs dispensed for treatment or diagnostic purposes during the ASTC surgical visit and dispensed for take home purposes shall be included in the approved per visit rate.

Non-Facility Services

Facility services that are not considered facility services (e.g. physician services, laboratory, X-ray, or diagnostic procedures performed by independent facilities or practitioners) must be billed by the provider rendering such services on a fee-for-service basis. However, if the ASTC provides the lab or X-ray service, the facility may not bill separately if the lab or x-ray service was provided on the day of the surgery. The ASTC may bill separately if the lab or X-ray service was provided on a date other than the date of the surgery.

Additional information on covered services can be found on the IL HFS website in the ASTC Handbook. https://www.illinois.gov/hfs/SiteCollectionDocuments/g200.pdf

Claim Form

ASTC services must be submitted on a UB-04 claim form or using the 837I electronic claim format and also include **Type of Bill 83X**.

Ambulatory Procedures Listing (APL): Note APL Section applies prior to 7/01/2020 DOS only.

The APL is a compilation of procedures that have been determined by HFS to be either unique to or most appropriately provided in the hospital outpatient or ambulatory surgical treatment center setting. Not all procedures will be applicable to the services provided in an ASTC. Services in accordance with covered Ambulatory Procedures Listing (APL) codes <insert link> are eligible to be billed. An outpatient ASTC claim must contain at least one procedure code listed in the APL.

When any service listed in the APL is performed on a given day, all services provided on that day must be billed on a single outpatient institutional claim. The HFS APL listing can be found here: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/AmbulatoryProceduresListing.aspx

Failure to have an APL code, Healthcare Common Procedure Coding System (HCPCS), ED revenue code, and/or OBV revenue code on the claim will result in the rejection of entire claim.

Enhanced Ambulatory Patient Grouping (EAPG)

Effective with dates of service beginning July 1, 2014, all outpatient hospital and ASTC claims are grouped and priced through 3M™ Enhanced Ambulatory Patient Grouping System (EAPG) software or similar MCO grouper software. The all-inclusive EAPG PPS payment is considered to cover all services provided by salaried ASTC personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment on the ASTC premises, and all X-ray, laboratory and therapy provided to the patient on the same day.

E. Service Limitations and Requirements

Hysterectomy

A hysterectomy is a covered service only when it is done for medical reasons and is not done solely to accomplish sterilization. A claim will only be processed if the information on the completed <u>Form</u> <u>1977 Acknowledgement of Receipt of Hysterectomy Information</u> indicates that the patient was informed that the hysterectomy will render her permanently incapable of reproducing. <u>Completion</u> of this form is required regardless of age. The UB-04 claim (indicating a hysterectomy was

performed) with the HFS 1977 attached must be sent together to the MCO for the claim to be processed.

Sterilization Procedures Other Than a Hysterectomy (Appendix F)

ASTC may submit claims 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.

The HFS 2189 form <insert link: https://www.illinois.gov/hfs/SiteCollectionDocuments/hfs2189.pdf must be completed and attached to the UB-04 when submitting to the MCO for the claim to be processed.

Abortion Services

Effective 11/01/2019 all abortion claims for services need to be submitted to HFS directly. This directive pertains to both Health Choice Illinois members and traditional fee for service members. Details on submitting claims to HFS can be found here.

F. Prior Authorization

Refer to the General Claim Submission Guidelines for all Provider Types <insert link iii. Prior Authorization> in this manual for information by MCO on prior authorization requirements and request process.

XXX. Durable Medical Equipment (DME)

A. Purpose

The purpose of this section is to outline the billing policies and procedures related to Durable Medical Equipment providers. For information on billing for <u>Orthotic, Prosthetic and Pedorthic Services</u>, please refer to that section within the manual.

B. Provider Type

This section applies to Provider Type 063 - Other Providers of Medical Equipment/Supplies in the IMPACT system.

C. IMPACT Enrollment Requirements

Provider must be a registered provider of DME services (PT 063) in the IMPACT system with one or more of the Categories of Services (COS) listed below and should use Taxonomy Code 332B00000X.

Provider Type Code	Provider Type Description
63	Other Providers of Medical Equipment/Supplies (Non-registered)
Category of Service Code	Category of Service Description
41	Medical equipment/prosthetic devices
48	Medical Supplies

NOTE: Eligible providers are those who supply or service:

- nondurable medical supplies
- durable medical and respiratory equipment
- prostheses or orthotics
- oxygen
- hearing aids

Audiologists who dispense hearing aids, long-term care facilities that dispense oxygen and hospitals need to specifically request that their IMPACT enrollment include approval to dispense durable medical equipment and supplies.

D. Coding and Billing Guidance

MCOs accept and process claims with allowable DME codes according to the HFS <u>DME fee</u> schedule. The fee schedule and corresponding <u>key</u> provides a complete listing of covered DME codes. Claims are to be submitted on the CMS-1500 form or the 837P electronic format. Refer to the <u>General Claim Submission for all Providers</u> in this manual for further information on claim requirements.

PLEASE NOTE: MCOs follow HFS' limitations on quantities listed in the DME/OPP fee schedule. Exceeding listed quantity limits is allowed when medically necessary and prior authorization from the MCO is obtained. Additionally, HFS indicates on the DME fee schedule whether the equipment or item is covered for residents of Long Term Care facilities.

Other DME Billing Requirements:

- DME requires a prescription to rent or purchase, as applicable, before it is eligible for coverage.
- All claims must include a diagnosis and the coding must reflect the actual services provided and the materials dispensed.
- Providers may only bill the MCO after the DME or OPP item has been dispensed.
- Ensure all appropriate prior authorizations are obtained before submitting a claim.
- Bill the applicable modifier after all HCPCS codes (including, but not limited to NU, UE, RR, etc.).
- Maintenance and repair modifiers should be the first modifier listed after the procedure code

E. Covered Services

The following general types of DME products and services are covered, subject to limitations in the DME fee schedule and MCO prior authorization policies:

- Nondurable Medical Supplies Items that have a limited life expectancy, including, but not limited to, surgical dressings, bandages, disposable syringes, etc. These items are used for an individual's care for life maintenance or to expedite hospital discharge and enable the person to be cared for at home.
- Durable Medical Equipment Items that can withstand repeated use, are primarily designed for medical purposes, generally not useful in the absence of illness, disability, infirmity or impairment, and appropriate for use in the home.

- Prostheses and Orthoses Corrective or supportive devices prescribed to artificially replace a
 missing portion of the body or to prevent or correct physical deformity or malfunction, or to
 support a weak or deformed portion of the body.
- Respiratory Equipment and Supplies Respiratory items, including oxygen, necessary as a life saving measure, for prevention of a medical emergency or institutionalization, or to facilitate a discharge to home.
- Repair and Modifications Repair and modification of necessary durable medical equipment, prostheses, orthoses and hearing aids is limited to patient-owned items.
- Rental of Medical Equipment Under certain circumstances, such as when a patient's need is known to be temporary, coverage will be for rental rather than purchase of an item. Certain items will be covered on a rent-to-own basis or a continuous rental basis.
- Loaner Item Coverage will be limited to one month rental while repairs are being completed on patient-owned equipment.
- Monaural or binaural hearing aids Items required to improve or correct a hearing deficit.

F. Non-Covered Services

Services for which medical necessity is not clearly established are not covered. The list below includes, but is not limited to, some DME services/supplies that are not covered:

- Items or services ordered by terminated or barred providers
- Items or services provided for the convenience of patients or their families for which medical necessity is not clearly established
- Items or services inappropriate for the patient's medical condition
- Items or services covered by another agency
- Items or services that require prior approval, but approval has not been obtained
- Disposable items, when a permanent equivalent exists
- Prepackaged "kits" when components are available in bulk at lower cost.
- Stock orthopedic shoes, unless used in conjunction with a brace
- Medical equipment and supplies for residents of long term care facilities
- Prostheses inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function, or eliminate a functional disability
- Items or services provided as part of a hospital inpatient stay
- Items or services provided as part of a hospital outpatient visit that is billed under the EAPG process.
- Items or services fabricated, fitted or dispensed without an appropriate license
- Any item or service when a less expensive item or service is available and appropriate to meet the patient's need
- An item supplied prior to the participant's eligibility for assistance.
- Exercise equipment
- Equipment used for completion of diagnostic testing, such as oximeters, or heart monitors

XXXI. Diabetes Prevention Program (DPP) and Diabetes Self-Management and Education Services

A. Purpose

The purpose of this section is to outline the billing policies and procedures for Diabetes Prevention Program (DPP) and Diabetes Self-Management and Education Services (DSMES) providers.

B. Provider Type

i. IMPACT Registration

Providers must obtain a <u>new</u> NPI and be enrolled in IMPACT as a Facility, Agency, Organization (FAO) with a Specialty of DPP (no sub-specialty) and/or a Specialty of DSMES (no subspecialty), with a taxonomy code of 174H00000X (Health Educator)

 ALL providers must obtain a new NPI and complete a new IMPACT enrollment, even if they are already enrolled as a different provider type (e.g., FQHC, RHC, Hospital). You cannot just add a DPP or DSMES specialty to a current enrollment.

ii. Place of Service

The accepted Place of Service (POS) codes for DPP and/or DSMES services are:

02 – Telehealth*	13 – Assisted Living Facility
03 – School-based Clinics	14 – Group Home
04 – Homeless Shelter	19 – Outpatient Hospital-Off Campus
11 - Office	22 – Outpatient Hospital-On Campus
12 - Home	99 – Other Place of Service (community-based setting

^{*} Use the GT modifier for telehealth visits

C. Billing and Coding

i. DPP Services

a. Eligibility for Services

Members are eligible for DPP services if they:

- o are between the ages of 18 and 64;
- o are overweight or obese (BMI of \geq 25 kg/m2 or \geq 23 kg/m2 if Asian) and
- have elevated blood glucose level **or** history of gestational diabetes mellitus (GDM):
 - Fasting glucose of 100 to 125 mg;
 - Plasma glucose measure 2 hours after a 75gm glucose load of 140 to 198 mg/dl;
 - A1C level of 5.7 to 6.4; or
 - Clinically diagnosed GDM during a previous pregnancy

b. Billing for DPP Services

NOTE: For members that also have Medicare coverage, provider must bill Medicare as the primary payor before billing the Medicaid MCO. DPP services are reimbursed based on the following session and performance-based system, for both in-person and/or virtual services (see Table 1). Note that all codes can only be billed once in a 365-day time period.

TABLE 1: DPP Code and Milestone Structure

Event	HCPCS Code*	Virtual or Telehealth Modifier**	Virtual or Telehealth Make-up Session Modifier**
Milestone 1	G9873 - 1 st core session attended	GT	none
Milestone 2	G9874 – 4 total core sessions attended	GT	VM
Milestone 3	G9875 – 9 core sessions attended	GT	VM
Milestone 4	G9876 – 2 sessions in months 7-9, 5% weight loss not achieved; OR G9878 – 2 sessions in months 7-9, 5% weight loss achieved	GT	VM
Milestone 5	G9877 - 2 sessions in months 10-12, 5% weight loss not achieved; OR G9879- 2 sessions in months 10-12, 5% weight loss achieved	GT	VM
Performance:	G9880 – 5% weight loss from baseline achieved	GT	none

^{*} All codes can only be billed once in a 365-day time period

DPP Diagnosis Codes

Because DPP services are only reimbursed for eligible members, there are specific diagnosis codes required on the claim:

- For each initial claim, DPP providers must indicate TWO ICD-10 diagnoses codes on the claim:
 - 1. For elevated blood glucose (R73.01, R73.02, R73.03) or history of GDM (Z86.32); and
 - 2. For BMI level (Z68.23 Z68.45)
 - Indicate appropriate R code based on one of 3 scenarios:
 - Member presents a formal provider referral with R code indicated; or
 - DPP provider receives blood test results from the member's MCO or health care provider, with proper consent and authorization; or
 - Member presents blood test results with the DPP provider may use to identify appropriate R code according to the code definition
- For each <u>subsequent</u> claim, DPP providers only need to provide only the R or Z code used on the <u>initial</u> claim. They do NOT need to include a BMI diagnosis code on any subsequent claim.
- The acceptable diagnosis codes can be found in Tables 2 and 3 on the following page.

^{**} If both modifiers are used, GT must be the first one listed

TABLE 2: DPP Diagnosis Codes - Diabetes

ICD-10 Code	Description	Definition							
R73.01	Impaired fasting glucose	Fasting plasma glucose 100 to 125mg/dL (5.6 to 6.9 mmol/L							
R73.02	Impaired glucose tolerance - Oral	Two-hour plasma glucose value during a 75g OGTT between 140 and 199 mg/dL (7.8 to 11.0 mmol/L							
R73.03	Prediabetes	Hemoglobin A1C of 5.7 to 6.4 percent							
Z86.32	Personal history of gestational diabetes	 Member presents a formal provider referral with Z code indicated; OR DPP provider receives blood test results or provider note from the member's MCO or provider, with proper consent and authorization by member; OR Member presents blood test results or provider note indicating history of GDM, or normal postpartum A1C or glucose level and GDM diagnosis during a previous pregnancy 							

TABLE 3: DPP Diagnosis Codes – BMI

ICD-10 Code	Description	ICD-10 Code	Description
Z68.23	Body mass index (BMI) 23.0-23.9, adult	Z68.34	Body mass index (BMI) 34.0-34.9, adult
Z68.24	Body mass index (BMI) 24.0-24.9, adult	Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.25	Body mass index (BMI) 25.0-25.9, adult	Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.26	Body mass index (BMI) 26.0-26.9, adult	Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.27	Body mass index (BMI) 27.0-27.9, adult	Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.28	Body mass index (BMI) 28.0-28.9, adult	Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.29	Body mass index (BMI) 29.0-29.9, adult	Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.30	Body mass index (BMI) 30.0-30.9, adult	Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.31	Body mass index (BMI) 31.0-31.9, adult	Z68.43	Body mass index (BMI) 50.0-59.9, adult
Z68.32	Body mass index (BMI) 32.0-32.9, adult	Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.33	Body mass index (BMI) 33.0-33.9, adult	Z68.45	Body mass index (BMI) ≥ 70, adult

ii. DSMES Services

a. Eligibility for Services

Members are eligible for services if they:

- Are between the ages of 18 and 64 with documentation of a diagnosis of type 1, type 2 or gestational diabetes
- Have a diagnosis made using the following criteria:
- fasting glucose > 126 mg/dL on two separate occasions
- 2-hour post-glucose challenge > 200 mg/dL on two separate occasions
- random glucose test > 200 mg/dL with symptoms of uncontrolled diabetes

b. Billing for DSMES Services

NOTE also that members who also have Medicare eligibility, providers must bill Medicare as the primary payer before billing the Medicaid MCO.

The following codes are to be used in billing for DMSMES services:

Session	HCPCS Code	Unit	Limitation
Individual Outpatient DSMES	G0108 Diabetes outpatient self-mgt training services, individual	30 minutes	6 units (3 hours) in 12 mo. period
Group Outpatient DSMES (2 or more)	G0109 Diabetes outpatient self-mgt training services, group session	30 minutes	30 units (15 hours) in 12 mo. period

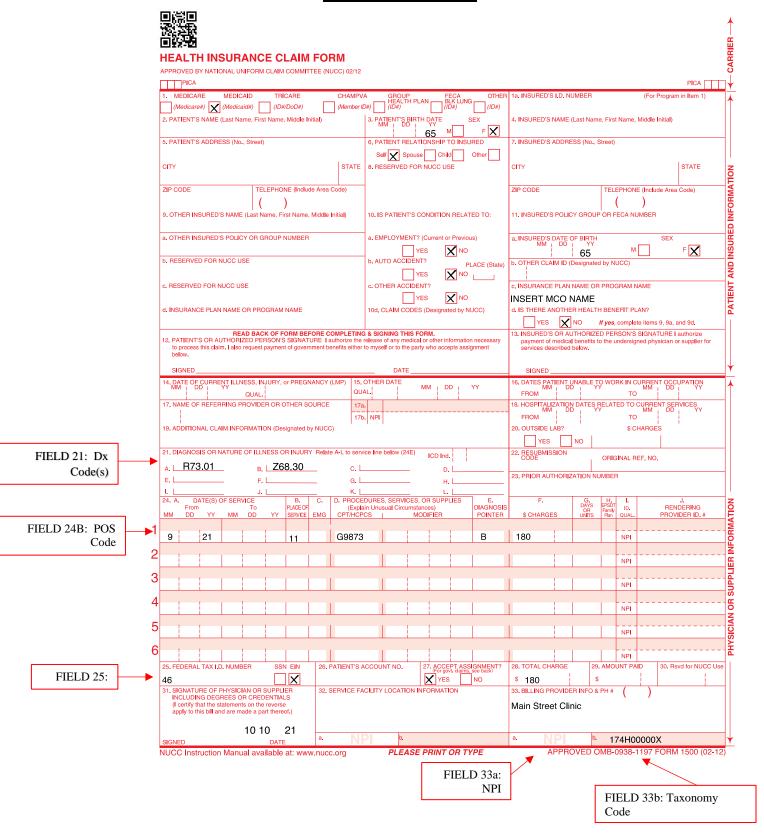
The following diagnosis codes are to be used for billing on the **initial** claim for services:

ICD- 10 Diagnosis Code	Description
E10	Type 1 diabetes mellitus
E11	Type 2 diabetes mellitus
024	Diabetes mellitus in pregnancy, childbirth, and the puerperium

D. Sample Claim Forms

Sample claims for DPP and DSMES services can be found on the following pages.

DPP Sample Claim



DSMES Sample Claim

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Appendix A: List of HFS Registered Childrens Hospitals

Medicaid ID	NPI	Hospital Name
370723793006	XXXX941105	Abraham Lincoln Childrens Hosp
364251846002	XXXX581725	Alexian Bros Childrens Hosp
430738490001	XXXX935891	Cardinal Glennon Childrens Hsp
390812532001	XXXX482022	Childrens Hosp of Wisconsin
370662569009	XXXX734127	Childrens Hospital of Illinois
363488183008	XXXX894990	Comer Childrens Hospital
362169147027	XXXX375082	Hope Childrens Hospital
362170866002	XXXX387388	Ingalls Childrens Hospital
362170143001	XXXX146430	La Rabida Childrens Hosp
362170833007	XXXX234535	Lurie Childrens Hospital
362169147026	XXXX539730	Lutheran General Childrens Hos
370661220012	XXXX099098	Memorial Med Ctr Childrens Hsp
370661230003	XXXX861330	Passavant Area Childrens Hosp
430666765002	XXXX117532	Ranken Jordan A Ped Rehab Ctr
364015560005	XXXX361748	Ronald Mcdonalds Childrens Hsp
362174823005	XXXX908728	Rush Childrens Services
362193608002	XXXX656538	Shriners Hospital for Children
362193608001	XXXX343447	Shriners Hospital for Children
361509000006	XXXX733681	Sinai Childrens Hospital
370661238009	XXXX637591	St Johns Childrens Hospital
430654870001	XXXX727663	St Louis Childrens Hospital
370661250009	XXXX729036	Taylorville Mem Childrens Hosp

Appendix B: Guidelines Specific to General Acute Care and Children's Hospital **Billing Guidelines**

Guidelines Specific to General Acute Care and Children's Hospital Billing

References:

Published by IAMHP October, 3 2016 specifically created to cease P59 and P60 Errors on claims to

https://iamhp.net/resources/Pictures/General%20Acute%20Care%20and%20Children's%20Hospit als%20Billing%20Guidelines%20-%20IAMHP%20Provider%20Memo.pdf

https://www.illinois.gov/hfs/SiteCollectionDocuments/110316ErrorCodes.xlsx

Error		Explanation
P59	Care Not Appropriate For Children's Hospital	A claim was submitted for a children's hospital where one of the following apply: 1) the participant was 18 years of age or older on the date of admission, or 2) the participant was under age 18, but the taxonomy code for inpatient psychiatric or for inpatient rehabilitation was reported, or 3) claim was submitted with incorrect principal diagnosis coding, or 4) claim was submitted with incorrect DRG coding. Review the medical records and the coding on the rejected claim. If an error is found, submit a corrected claim. If assistance is needed, contact a hospital billing consultant at 1–877-782-5565.
P60	Care Not Appropriate For Adult Hospital	A claim was submitted with an adult hospital number and the patient is under age 18 on the date of admission and one of the following apply: 1) a General inpatient Taxonomy Code was submitted on the claim and the DRG code is incorrect, or 2) an Outpatient General Taxonomy Code was submitted on the claim and the Principal Diagnosis code is incorrect, or 3) an Outpatient Renal Dialysis "Exconomy Code was submitted on the claim and the Principal Diagnosis code is incorrect. Review the medical records and the coding on the rejected claim. If an error is found, submit a corrected claim. If assistance is needed, contact a hospital billing consultant at 1-877-782-5595.

Detailed Example Describing Billing Scenario

The following information denotes how the allowable Hospital Inpatient Categories of Services (COS) are to be billed for providers who have both a registered General Acute Care and Children's Hospital NPIs.

1. Children's Hospital NPI - less than the age of 18 years on the date of admission:

Children's Hospital NPIs **must always** be used for members less than the age of 18 years on the date of admission (with the exception of Labor and Delivery) for the following inpatient

COS:

020 Inpatient Hospital Services (General)
023 Inpatient Hospital Services (ESRD)

<u>labor-and Delivery Claim Newborn Claims</u> (APR-DRG 626 or 640) for members less than the age or a years or me use of admission must be billed using the General Acute Care NPI and the appropriate taxonomy code from the following list:

- 282NC2000X (General Acute Care Hospital Children) 281PC2000X (Chronic Disease Hospital Children) 282NW0100X (General Acute Care Hospital Women) 282N00000X (General Acute Care Hospital): or 282NR01000X (General Acute Care Hospital Rural)

Existing IAMHP Guidance since 2016 has stated verbiage nerically listed as <u>'Labor and Delivery'</u> claims. This verbiage was specifically intended to be a 'generic statement' that would include APR DRG codes:

626 representing a Normal Newborn, bwt 2000 - 2499G 640 representing a Normal Newborn, bwt>2499G as well as the APR DRGs 540-546 and 560-566 delinating the type of labor.

Specific feedback is requesting a verbiage in the guidance to state 'NEWBORN' for 626 and 640, and to no longer use the generically listed term of 'Labor and Delivery' claim.

Will billers understand this isn't specifically related to billing a 'newborn' claim? What is IHA's perspective of this change?

It was agreed in the 3/11 meeting that billers would understand the intent There are unique rules for the specific Illinois Hospital Systems that have this billing requirement. The next slide illustrates the specific hospital system impact

Use Case

Sample State of Illinois Provider System Examples that share HFS' 'Childrens Hospital' Designation and 'General Acute' Designation

Example Data from the HFS Provider Data Sent to the MCOs (MAP File)

HFS Medicaid ID	HFS associated NPI	HFS Provider Name
361509000006	XXXX733681	SINAI CHILDRENS HOSPITAL
362169147026	XXXX539730	LUTHERAN GENERAL CHILDRENS HOS
362169147027	XXXX375082	HOPE CHILDRENS HOSPITAL
362170143001	XXXX146430	LA RABIDA CHILDRENS HOSP
362170833007	XXXX234535	LURIE CHILDRENS HOSPITAL
362170866002	XXXX387388	INGALLS CHILDRENS HOSPITAL
362174823005	XXXX908728	RUSH CHILDRENS SERVICES
362193608001	XXXX343447	SHRINERS HOSPITAL FOR CHILDREN
362193608002	XXXX656538	SHRINERS HOSPITAL FOR CHILDREN
363488183008	XXXX894990	COMER CHILDRENS HOSPITAL
364015560005	XXXX361748	RONALD MCDONALDS CHILDRENS HSP
364251846002	XXXX581725	ALEXIAN BROS CHILDRENS HOSP
370661220012	XXXX099098	MEMORIAL MED CTR CHILDRENS HSP
370661230003	XXXX861330	PASSAVANT AREA CHILDRENS HOSP
370661238009	XXXX637591	ST JOHNS CHILDRENS HOSPITAL
370661250009	XXXX729036	TAYLORVILLE MEM CHILDRENS HOSP
370662569009	XXXX734127	CHILDRENS HOSPITAL OF ILLINOIS
370723793006	XXXX941105	ABRAHAM LINCOLN CHILDRENS HOSP
390812532001	XXXX482022	CHILDRENS HOSP OF WISCONSIN
430654870001	XXXX727663	ST LOUIS CHILDRENS HOSPITAL
430666765002	XXXX117532	RANKEN JORDAN A PED REHAB CTR
430738490001	XXXX935891	CARDINAL GLENNON CHILDRENS HSP

HFS Medicaid ID	HFS associated NPI			HFS Provider City	HFS	HFS Provider Zip First S	100000000000000000000000000000000000000	100	100	HFS	for	End date	Enrollment Begin Date	Enrollment End Begin Date CYD
Rush System Hos	Rush System Hospital Example													
362174823017	1326140583	RUSH UNIVERSITY MEDICAL CENTER	1653 W CONGRESS PKWY	CHICAGO	IL	60612	030	020	021	022	2004122	9999999	2004122	9999999
362174823005	1801908728	RUSH CHILDRENS SERVICES	1753 W CONGRESS PKWY	CHICAGO	IL	60612	030	020			1998244	9999999	1992275	9999999

Medicaid Beneficiary/Recipient at time of admit at time of admit is under 18 years of age

Rush System Example: This patient is admitted at the Rush Childrens Services 1753 W Congress Pkwy Scenario 1

Hospital billing determines APR DRG is 626

Because the patient is less than 18, 1653 W Congress Pkwy for Rush University Medical Center (HFS General Acute Registration) with NPI 1326140583 and General Acounte Care Hospital Taxonomy 282N0000X should be sent on the claim to the MCO based on HFS system requirements

Scenario 2

Hospital billing determines APR DRG is 540

*Because the patient is less than 18, 1653 W Congress Pkwy for Rush University Medical Center (HFS General Acute Registration) with NPI 1326140583 and General Acounte Care Hospital Taxonomy 282N0000X should be sent on the claim to the MCO based on HFS system requirements

Appendix C: ICD-9 to ICD 10 Crosswalk for Hospitals with General Acute and HFS defined Children's Hospital

	F02vor				Code Range		
	F03xx	F13xx	F04	F22	F68xx	Z87xx	
	F05xx	F12xx	F02xx	F23	F6xx	R37	
	F01xx	F16xx	F20xx	F24	F40xx	F5xx	
200 202	F10xx	F17xx	F2xx	F28	F45xx	F52xx	
290-302	F19xx	F18xx	F30xx	F3xx	F99	F65xx	
	F15xx	F05	F39	F44xx	F60xx		
	F11xx	F06xx	F33xx	F8xx	F21		
	F14xx	F53	F31xx	F4xx	F66		
	F45xx						
306	F52xx						
	F59						
	O019	О2хх	О60хх	О99хх	О30хх	О40хх	О89хх
	O0281	О44хх	О47хх	О98хх	О32хх	O41xx	О8хх
	0021	О45хх	О4хх	O24xx	ОЗЗхх	O42xx	082
	О0хх	О46хх	О31хх	О9хх	О34хх	О09хх	O85
630 – 677	О03хх	О6хх	O12xx	ОЗхх	ОЗ5хх	076	O22xx
	О04хх	О10хх	026хх	О25хх	О36хх	О64хх	О88хх
	Z3xx	О1хх	О90хх	О9Ахх	О43хх	О66хх	О91хх
	007хх	О14хх	О23хх	О75хх	O68	О69хх	О92хх
	О08хх	О15хх	О86хх	080	О7хх	071хх	094
	Z33 xx						
V22	Z34xx						
	O09XX						
	O092XX						
V23	O095XX						
	O096XX						
	O098XX						
V28	Z36						

Appendix D: MCO Sample EOPs

Aetna Better Health of Illinois	Pages 268-269
Blue Cross Community Health Plans	Pages 270-272
County Care Health Plan	Pages 273-274
Meridian Health	Pages 275-277
Molina HealthCare	Pages 278-281

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WHITE STOCK 202011230129

TEDD

Return Service Requested

1 0.7130 SP 0.500

SINGLE PIECE

վիկիրիակակակակիրկիկներներիակական

If you have any questions please contact the Claims Department at 1-866-329-4701 (TTY:711) or visit our website at www.actnabetterhealth.com/Illinois-medicaid



1 OF 3 F

Remit Date: 09/25/2020 0.00 Beginning Balance: Processed Amount: 00.000 Discount/Interest: 0.00 000,00 Net Amount: Refund Amount: 0.00 Amount Recouped: 0.00 000.00 Amount Paid: **Ending Balance:** 0.00 EFT100297 Check #: Check Amount: 000.00 Bank Account: XXXXXXXXXXXXX

XXXXX XXXXX XXXXXXXXX

T IN: XXXXXXXX NPI: XXXXXXXX Benefit Plan: Aetna Better Health of Illinois

Patient:XXXX XXXX X Patient Acct #: XXXXXXX Claim Status: PAID Member ID:XXXXXXXX Provider:XXXXXXX XXXXXX XXXXXX Severity of Illness: Claim#: XXXXXXXXXX Amount: 0.00 Date of Birth:01/01/1994 Refund Amount: Final DRG: Received Date: 20200812

ıe	Dates of Service	Serv	Mod	Rev	FFS/	Unit	Billed	Disallowed	Allowable	Patien	t Responsi	bility	COB	Processed	Discount/	Net
=	(From - Thru)	Code	Code	Code	CAP		Amount		Amount	Co-Pay	Ded.	Co-Ins	Paid	Amount	Interest	Amount
1	07/09/20	T4526			FFS	200	174.00	0.00	155.04	0.00	0.00	0.00	0.00	155.04	0.00	00.000
3	07/09/20	T4541			FFS	135	64.80	0.00	64.80	0.00	0.00	0.00	0.00	64.80	0.00	00.00
4	07/09/20	T4541			FFS	15	7.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- 100				(laim '	Fotals	246.00	0.00	219.84	0.00	0.00	0.00	0.00	219.84	0.00	00.00

Code/Description

4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING Line 2

151 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY/FREQUENCY OF Line 4

	Patient: XX Member ID: Date of Birth:// Final DRG: ace of Service:12	XXXX)	XXXX.	XXXX	XXXX	CXX	Authoriz	ation ID:	(XXXXXXX (XXXXXXX		xxxxx	Co-Ins Paid Amount Interest Ar 0.00 0.00 127.56 0.00 0.00 0.00 0.00 10.07 0.00 0.00 0.00 0.00 0.00 0.00 0.00				
jine '	Dates of Service (From - Thru)	Serv Code	Mod Code		FFS/ CAP		Billed Amount	Disallowed	Allowable Amount	Patier Co-Pay	nt Responsi Ded.	bility Co-Ins				Net Amount
2	07/09/20	B4088			FFS	1	210.00	0.00	127.56	-	0.00		0.00	127.56	0.00	000.00
3	07/09/20	B4035			FFS	1	12.49	0.00	10.07	0.00	0.00	0.00	0.00	10.07	0.00	00.00
4	07/09/20	B4035			FFS	29	362.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
-				(laim '	Totals	584.70	0.00	137.63	0.00	0.00	0.00	0.00	137.63	0.00	000.00

4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING

151 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY/FREQUENCY OF

PI	Patient:NID Member ID:215 Date of Birth:06/0 Final DRG: acc of Service:12	225481		С			Authoria	nt Acct #:35 tation ID: Provider: ^{SF} of Illness:	38550500A HELD DENV	ER HLT C	CARE COR	inc/	Refund Am	tatus: PAID nin#: 10000 ount: Date: 20200	002 0 9727 0.00	D)
2	Dates of Service	Serv	Mod		FFS/	Unit	Billed	Disallowed	Allowable	Patien	rt Responsi	bility	COB	Processed	Discount/	Net
5	(From - Thru)	Code	Code	Code	CAP		Amount		Amount	Co-Pay	Ded.	Co-Ins	Paid	Amount	Interest	Amount
1	07/09/20	T4528			FFS	196	211.68	0.00	187.92	0.00	0.00	0.00	0.00	187.92	0.00	000.00



XXXXX XXXXXX XXXXXX XXXXX

T IN: XXXXXXXXXX NPI: XXXXXXXX

WHITE STOCK

TEDET

If you have any questions please contact the Claims Department at 1-866-329-4701 (TTY:711) or visit our website at

www.aetnabetterhealth.com/Illinois-medicaid

2 OF 3 F

09/25/2020 Remit Date: EFT100297 Check #:

Aetna Better Health of Illinois Benefit Plan:

Messages

Aetna Better Health of Illinois offers the following resources for additional information and assistance:

- 1) Claims Inquiry: please call 866-329-4701 (TTY: 711) Opt 3, Monday Friday, 8:30 AM to 5:00PM CT to verify that your claim processed correctly, or for clarification of information. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.
- 2) Revised Claims Resubmission and Reprocessing: A "resubmission" is defined as a claim originally denied because of missing information or incorrect coding that prevents Aetna Better Health from processing the claim. Per Federal regulation 42 CFR § 424.44(a), health care providers must submit a corrected claim within 6 months from the date of service.

Mark at the top of the claim "RESUBMISSION" and include the following:

- Statement indicating the correction or request:
- Copy of the original claim;
- Copy of the remit notice showing the claim denial;
- Documentation supporting request;
- Any additional information required to process the claim;

Mail to:

Aetna Better Health of Illinois P.O. Box 66545 Phoenix, AZ 85082-6545

3) To Appeal a Claim Denial:

Attention health care providers not contracted with Actna Better Health directly or through its subcontracted networks: If you do not agree with this decision, you have the right to appeal. An appeal is a review by people independent of the original claim decision. You may submit an appeal for a claim denied based on error or absence of fact, except for timely filing. Federal regulations 42 CFR 42 § 422.504(g) requires us to protect Actna Better Health members from financial liability, therefore, appeals must include a signed Waiver of Liability (WOL) form, (available at www.actnabetterhealth.com/Illinois).

To appeal a claim denial, write a letter and mark the top of the request "appeal" and include the following:

- Statement indicating factual or legal basis for appeal;
- A signed "Waiver of Liability";
- Copy of the original claim
- Copy of the remit notice showing the claim denial.
- Any additional information, clinical records or documentation

Mail to:

Actna Better Health of Illinois ATTN: Grievance & Appeals P.O. BOX 81040 Cleveland, OH 44181

Please note: A dispute reference number will be the adjusted claim number of the initial claim that was disputed. The dispute claim decision will show up on this remittance as the claim number with an addition of two digits (A1 for example).

4) To Appeal a Claim Payment Amount

Attention health care providers not contracted with Aetna Better Health directly or through its subcontracted networks: If you do not agree with the payment amount, you have the right to dispute the payment amount and file an appeal. An appeal is a review by people independent of the original claim decision. You may submit an appeal for a claim payment dispute when you believe that under original Medicare you would have been paid a different amount.

To appeal a claim payment, write a letter and mark the top of the request "appeal" and include the following:

- Statement indicating factual or legal basis for appeal;
- Documentation showing that you would have received a different payment under original
- Copy of the original claim
- Copy of the remit notice showing the amount paid

Note: Appeals must be filed within 60 days from the date of this remit

Mail to:

Aetna Better Health of Illinois ATTN: Grievance & Appeals P.O. BOX 81040 Cleveland, OH 44181

Please note: A dispute reference number will be the adjusted claim number of the initial claim that was disputed. The dispute claim decision will show up on this remittance as the claim number with an addition of two digits (A1 for example)

- 5) Providers are encouraged to review our website: www.aetnabetterhealth.com/Illinois for updates to our Provider Manual and provider notifications.
- 6) If you would like to report healthcare fraud related issues please call the toll-free hotline at 1-866-670-6885, contact us by e-mail at aetnasiu@aetna.com, or online at https://www.aetnabetterhealth.com/illinois/fraud-abuse

If you are returning the original check issued by Aetna, please mail within 60 days to:

> Aetna Better Health of Illinois Attn: FINANCE 4500 E. Cotton Center Blvd. Phoenix, AZ 85040

processing errors within 6 Aetna Better Health of Illing Attn: FINANCE



269 Proprietary

Please mail a refund check for any or P.O. BOX 842499 Dallas, TX 75284-2499



Servicing Provider NPI: 0999999999

				Patien	t and Service	s Informati	on					
Account Number	99999999999)	999	Plan Nam	e: XXXX	XXXXXXX	XXXX					
Patient Name XXXX	(XXXXXXX	XXXXXX	Claim	Id XXXXX	XXXX							
							Patient Re	sponsibility				
Dates of Service	Proc/Rev Code	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Co Pay	Co Ins	Ded Amt	Non Cvrd	Interest Owed	Plan Payment	Remarks
mm/dd/yy mm/dd/yy mm/dd/yy mm/dd/yy	I	999,999.99 999,999.99	999,999.99 999,999.99	999,999.99 999,999.99	999,999.99 999,999.99	9,999.99 9,999.99	9,999.99 9,999.99	,		99.99 99.99	999,999.99 999,999.99	XXX XXX
Claim totals: 17276M	000200	999 999 99	999 999 99	999,999,99	999,999.99	9,999,99	9 999 99	9 999 99	9,999,99	99 99	999 999 99	

Current Payment Amount: 999,999.99

Provider Sequestration Amount: 999,999.99

 Prior Paid Amount:
 999,999.99

 Net Payment Amount:
 999,999.99

For Questions, Call Provider Services at 1-877-723-7702. TTY for the Hearing Impaired, Call 711. 8:00 a.m.-8:00 p.m., 7 days a week from October 1st through February 14th. 8:00 a.m.-8:00 p.m., Monday through Friday February 15th through September 30th

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association.



	Amount	Amount	Adjusted	Primary		Patient Res	ponsibility		Interest	Plan Payment
	Billed	Allowed		Payor Pmt	Co Pay	Co Ins	Ded Amt	Non Cvrd	Owed	
Provider total: 9999999999	999,999.99	999,999.99	999,999.99	99,999.99	999,999.99	99,999.99	9,999.99	999,999.99	9,999.99	999,999.99

Payment Summary

Payment Date: Total Charged: 999,999.99 mm/dd/yy 999999999 Check #: Total Cons Charged 1: 999,999.99 Paid To: XXXXXXXXXXXX **Total Denied:** 999,999.99 Tax ID: 999999999 Total Allowed: 999,999.99 XXXXXXXXX Non Paid 2: Reference Id: 999,999.99 **Prior Paid:** 999,999.99 Interest Owed: 999,999.99 1 - Larger of contracted amount and charges. **Provider Sequestration Amount:** 999,999.99 2 - Includes items such as COB and Patient Responsibility **Gross Paid:** 999,999.99 Reductions: 999,999.99 Automatic Recovery: 999,999.99 999,999.99 Other Recoveries: Net Check Amount: 999,999.99

Explanation of Claims Handling

Payment Reduction and Recovery Summary:

	Recoveries on	Reductions on		
Previous Balance	this Remittance	this Remittance		New Balance
99,999.99	<u> </u>	+ 99,999.99	=	99,999.99

For Questions, Call Provider Services at 1-877-723-7702. TTY for the Hearing Impaired, Call 711. 8:00 a.m.-8:00 p.m., 7 days a week from October 1st through February 14th. 8:00 a.m.-8:00 p.m., Monday through Friday February 15th through September 30th

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association.



Negative Balance Details:

Creation Date	Reduction Type	Original Claim Information	Original Reduction	Prior Recovery	Current Recovery	Current Balance
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
		Dates of Service: mm/dd/yy- mm/dd/yy				
		Patient Account #: XXXXXXXXXXXXXX				
		Original Claim Control #: XXXXXXXX				
		Original Check #: XXXXX				
		Original Check Date: mm/dd/yy				
		LOB: XXXXXXXXXXXXXXXX				
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
		Dates of Service: mm/dd/yy- mm/dd/yy				
		Patient Account #: XXXXXXXXXXXXXXXX				
		Original Claim Control #: XXXXXXXX				
		Original Check #: 99999				
		Original Check Date: mm/dd/yy				
		LOB: XXXXXXXXXXXXXX				
mm/dd/yy	Manual Reduction		9999.99	9999.99	9999.99	9999.99

9999.99

For Questions, Call Provider Services at 1-877-723-7702. TTY for the Hearing Impaired, Call 711. 8:00 a.m.-8:00 p.m., 7 days a week from October 1st through February 14th. 8:00 a.m.-8:00 p.m., Monday through Friday February 15th through September 30th

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association.

ABC HOSPITAL 11111111111 \$180.15 Page 1 of 2



OOOO493 01 MB 0.421 **AUTO T3 0 1067 60090-045757-C08-P00000-I 234

Ֆրեկլիութվեկիլ, հղեն հիլիկուրենի հոլորիու Ալիուիլյոլ ինչին

ABC HOSPITAL

123 ANY STREET PHILADELPHIA PA 19103

EXPLANATION OF PAYMENT

Payment Date: 01/16/2019 11111111111 Payee ID: 3111111111 Tax ID:

Check Number: 0008213690

Claim Count:

\$796.90 **Total Charges: Total Payment:** \$180.15 Total Provider Adj: \$0.00 **Payment Amount:** \$180.15

Contact us at: www.CountyCare.com 312-864-8200 855-444-1661

Get Paid Faster! Register for ERA/EFT at https://register.instamed.com/eraeft and enter Registration Code: WUHL69

PROVIDER CLAIM SUMMARY

	Service To	Procedure	No. of Units	Amount Billed	Allowed	Paid	Adjustments	СОВ	Not Covered	Withhold	Adjustment Reason	Remarks
Patient: 1	333333333	SMITH JOHN		Provide	r: 1111111111 A	BC HOSPITAI		Member	r: 133333333 SN	MITH JOHN		
Interest:				Claim I	D: 2018353C12	233800		Patient .	Account Numb	er: ABCD-11-2	22-3	
11/27/18	11/27/18	A0429(RH)	1	750.00	142.63	142.63	0.00	0.00	607.37	0.00	CO-59	
11/27/18	11/27/18	A0425(RH)	6.7	46.90	37.52	37.52	0.00	0.00	9.38	0.00	CO-59	
Total for	Claim			796.90	180.15	180.15	0.00	0.00	616.75	0.00		

Adjustment Reason Codes Remarks Codes

Code	Description	Code	Description
CO-59	Processed based on multiple or concurrent procedure rules. (For		
	example multiple surgery or diagnostic imaging, concurrent anesthesia.)		

CountyCare Health Plan has a new address for all written claims communications, including paper claims and appeals: P.O. Box 211592, Eagan, MN, 55121-2892.

This address is currently active, and we encourage you to start using it today. Effective October 1, 2018, the old address will no longer be in service.

Get Paid Faster! Register for ERA/EFT at https://register.instamed.com/eraeft and enter Registration Code: WUHL69



CountyCare Health Plan PO Box 211592 Eagan MN 55121-2892

Wells Fargo Bank, N.A. San Francisco, CA

No. 0008213690 01/16/19

11-24/1210

ONE HUNDRED EIGHTY and 15/100

VOID VOID VOID VISOID

\$180.15

PAY TO THE ORDER OF

ABC HOSPITAL 123 ANY STREET PHILADELPHIA PA 19103

0001374906

XXXXXXXXXX XXXXXXXX



CountyCare encourages participating providers to enroll in our Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) service. Using EFT/ERA helps reduce costs, speeds secondary billings, and can improve cash flow. Enrollment information can be found at www.CountyCare.com within the Claims and Electronic Transactions page.

Appeals must be submitted in writing within 60 working days of the date of payment or denial. Please submit the written appeal by mail with a copy of the Explanation of Payment and other supporting documentation to:

CountyCare PO Box 803758 Chicago, IL 60680

For complete information about your appeal rights and the appeal process please refer to the Provider Handbook.

If you have questions regarding this statement or the appeals process, please call 312-864-8200. If you suspect fraud, please call 844-509-4669.

Meridian Health Plan CLAIMS DEPARTMENT 800-203-8206

Pre-Release Preview

Date Processed: 02/27/2019 Check #: 0

Check Amount: 206.11

Alt ID#:

Insured:				Ins	sured Id:			Pat	tient Acco	unt#:			
Clain	n #6	Provider/Practitioner:											
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes		
02/20/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	45-CO MHPIL		
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40			
								Interest	Amount	0.00			
								Total Clain	Amount	23.40			

Refund Check# Insured: Insured Id: Patient Account #: (Provider/Practitioner: Claim #: Dates of Comment Proc Billed Provider Not Allowed Deductible Co-Pay Net Co-Ins Service Codes Code Adjust Amt Covered Carrier Amount 02/08/2019 99309 0.00 0.00 0.00 23.40 45-CO MHPIL 145.00 121.60 23.40 0.00 0.00 145.00 121.60 0.00 23.40 0.00 0.00 0.00 0.00 23.40 Totals

Refund Amount

0.00

nsured: Clain	1 #: (2000)			Ins	sured Id:	Provi	ider/Practiti		tient Acco	ount #: 🚾	
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/14/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40 4	5-CO MHPIL
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	

insured:				Ins	ured Id:			Pa	tient Acco	ount #:	
Claim	#:	Provider/Practitioner:									
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/20/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	45-CO MHPIL
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	

| Interest Amount | 0.00 | Total Claim Amount | 0.00 | Refund Amount | 0.00 | Refund Check #

201903010100

Date Processed: 02/27/2019 Check #: 0 Check Amount: 206.11

Alt ID#:

nsured:				Ins	sured Id:			Pa	tient Acco	unt#:	
Clain	1 #:					Provi	ider/Practiti	oner:			
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/20/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	45-CO MHPIL
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	
										0.00	

0.00 Interest Amount 23.40 **Total Claim Amount** 0.00 Refund Amount Refund Check #

nsured: Claim	# C	•	Insured Id: Patient Account #: Provider/Practitioner:								
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/20/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	45-CO MHPIL
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	

0.00 Interest Amount 23.40 Total Claim Amount Refund Amount 0.00 Refund Check #

nsured:				Ins	ured Id:			Pa	tient Acco	unt#:	
Claim #						Provi	der/Practitio	oner:			
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/20/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	15-CO MHPIL
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	

0.00 Interest Amount **Total Claim Amount** 23.40 0.00 Refund Amount Refund Check #

nsured:				Ins	ured Id:			Pa	tient Acco	unt #: 🚃	
Claim	#:					Prov	ider/Practiti	oner:			
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/19/2019	99308	109.00	90.09	0.00	18.91	0.00	0.00	0.00	0.00	18.91	45-CO MHPIL
	Totals	109.00	90.09	0.00	18.91	0.00	0.00	0.00	0.00	18.91	

0.00 Interest Amount **Total Claim Amount** 18.91 0.00 Refund Amount Refund Check#

Suite 720 Detroit, MI 48226

Meridian Health Plan CLAIMS DEPARTMENT 800-203-8206



2 OF 2 F

Pre-Release Preview

Date Processed: 02/27/2019 Check #: 0 Check Amount: 206.11

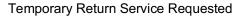
Alt ID#:

nsured:			Ins	ured Id:	Provi	ider/Practiti		tient Acco	unt#:		
Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/20/2019	99309	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	45-CO MHPIL
	Totals	145.00	121.60	0.00	23.40	0.00	0.00	0.00	0.00	23.40	
	-							Interest	Amount	0.00	

Previous Balance
Remittance Total
Interest Total
Check Amount

Comment	Comments
45-CO	Charges exceed your contracted/legislated fee arrangement.
MHPIL	Meridian Health Plan is an Illinois Medicaid HMO

"Effective 1/1/17 Meridian will require taxonomy on all claims. Claims submitted without taxonomy after 1/1/17 will be rejected and need to be resubmitted with taxonomy"







EXPLANATION OF PAYMENT

SUMMARY OF PAYMENT

Billed Amount: Contract/Allowed Amt: Disallow Amount:: Gross Plan Payable: COB Amt: Co-Pay: Refunds: Interest: Coinsurance: Deductible: FFS Withhold: Total Paid Amount:

Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

MOLINA® HEALTHCARE
Molina Healthcare of Illinois
200 Oceangate, 6th Floor
Long Beach, CA 90802

US BANK HAVRE, MT 93-455/929

VOID AFTER 90 DAYS

PAY

TO THE ORDER OF

To submit a corrected claim, please submit to:

Molina Healthcare of Illinois, Inc. P.O. Box 540 Long Beach, CA 90806

When submitting a corrected claim, claim must be stamped as "corrected claim". In addition, please do not attach any additional documentation (i.e. cover letter, clinical records, etc.) as this may cause the claim to be incorrectly interrupted as a complaint or dispute and the claim will be returned to you.

If you wish to file a provider dispute, please submit a written request to:

Molina Healthcare of Illinois Attention: Claim Disputes / Adjustments 1520 Kensington Rd, Suite 212 Oak Brook, IL 60523 Fax to (855) 502-4962

All disputes must be received within 90 days of Molina Healthcare's original remittance advice date in order to be considered. For any questions, please call: 1-855-866-5462

EXPLANATION OF PAYMENT



TOTAL AMOUNT:

***Msg:

					EXPLANA	TION OF	PAYME	NT						Ó
• DDMOLL	NI A®				Explanati	on of Pay	ment for:	:					400 / 2 4 / 10 / 2 4 / 3 / 3	452-000
MOLI	CARE				NPI: TAX I									JU5-UUU
Molina Healthcare of IL			Paid	Date:			С	heck or EFT Trace#						000452-000005-000014-004998
Claim Date Rev Line ServiceFrom Code ServiceThru cpt/hpc	ModMod Units 1 2 3 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan COB Payable Amount	Co-Pay Applied	Refund Amount Interest	Co- insurance Deductible	FFS Withhold	FSS Line CAP Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	2205313 1060
Patient Name: Rendering Provider Name:					Member ID#: NPI#:			er Claim Ctrl#: ram:		Patient Co	ntrol #:			1060CK01F
	_													
TOTAL AMOUNT:														
Claim Date Rev ine ServiceFrom Code ServiceThru cpt/hpc	ModMod Units 1 2 3 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan COB Payable Amount	Co-Pay Applied	Refund Amount Interest	Co- insurance Deductible	FFS Withhold	FSS Line CAP Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	
Patient Name: Rendering Provider Name:					Member ID#: NPI#:			er Claim Ctrl#: gram:		Patient Co	ntrol #:			
	_													
TOTAL AMOUNT:														
Claim Date Rev ine ServiceFrom Code ServiceThru cpt/hpc	ModMod Units 1 2 3 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan COB Payable Amount	Co-Pay Applied	Refund Amount Interest	Co- insurance Deductible	FFS Withhold	FSS Line CAP Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	
Patient Name: Rendering Provider Name:	-				Member ID#: NPI#:			er Claim Ctrl#: gram:		Patient Co	ntrol #:			



Molina Healthcare of IL

EXPLANATION OF PAYMENT

Explanation of Payment for:

NPI: TAX ID:

Paid Date:

Check or EFT Trace #

DESCRIPTION OF HIPAA ADJUSTMENT & REMARK

ADJ GRP CODE	DESCRIPTION
CO	Contractual Obligation
OA	Other Adjustment

ADJ RSN CODE	DESCRIPTION									
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)									
45	harge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and									
	must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO									
	depending upon liability)									
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification									
	Segment (loop 2110 Service Payment Information REF), if present.									
RMK CODE	DESCRIPTION									

J	
RMK CODE	DESCRIPTION
N19	Procedure code incidental to primary procedure.
•	

Appendix E: Educational EOPs by MCO

Aetna Better Health of Illinois	Pages 283-286			
Blue Cross Community Health Plans	Pages 287-288			
County Care Health Plan	Page 389			
MeridianHealth	Page 290			
Molina HealthCare	Pages 391-292			

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If you have any questions please contact the Claims Department at 1-866-329-4701 (TTY:711) or visit our website at

www.aetnabetterhealth.com/Illinois-medicaid

쬁

01/05/2021

Return Service Requested

ALL FOR AADC 630

16

• G	\rightarrow	Beginning Balance:	0.00
• H	\rightarrow	Processed Amount:	1,653.20
• I	\rightarrow	Discount/Interest:	0.00
• J	\rightarrow	Net Amount:	1,653.20
• K	\rightarrow	Refund Amount:	0.00
• L	\rightarrow	Amount Recouped:	0.00
• M	→	Amount Paid:	1,653.20
• N	\rightarrow	Ending Balance:	0.00
• 0	\rightarrow	EFT Reference #:	XXXXXXXXX
• P	\rightarrow	EFT Amount:	1,653.20
• Q	\rightarrow	Bank Account:	XXXXXXXXXX
			VV

Remit Date:

XXXXXXXXXXXXXXXXXXXXXXX

TIN: XXXXXXXXX

NPI: XXXXXXXXX

Benefit Plan: Aetna Better Health of Illinois

•	Patient:XXXXXXXXX							→ Patient Acct #:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX					Claim Status: PAID Claim#: XXXXXXXXXXXXX Refund Amount: 0.00 Received Date: 20201228				
	Line	Dates of Service (From - Thru)	Serv Code	Mod Code		FFS/ CAP		Billed Amount	Disallowed	Allowable Amount	Paties Co-Pay	nt Responsi Ded.	bility Co-Ins	COB Paid	Processed Amount	Discount/ Interest	Net Amount
	1	12/07/20	87636	TC	0300	FFS	1	355.00	0.00	14.72	0.00	0.00	0.00	0.00	14.72	0.00	14.72
	2	12/07/20	C9803	CR TC	0300	FFS	1	55.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		• E l		-	(Claim '	Totals	410.00	0.00	14.72	0.00	0.00	0.00	0.00	14.72	0.00	14.72

Code/Description

- 96 Non-covered charge(s).
- Line 2 96 NON-COVERED CHARGE(S)
 - N130 CONSULT PLAN BENEFIT DOCUMENTS FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.

Explanation of Payment Key

- A Member's Medicaid ID Number.
- B The amount billed on the claim.
- C Patient Control Number submitted on the claim.
- D -Contractual allowed amount.
- E Code/Description: This column contains codes that describe the reason for how claims were processed (paid or denied)
- F Net Amount: This column contains payment amount of the claim service line. Unpaid claims will contain a ".00" in this column.
- G Beginning Balance: Starting prepayment or advancement balance
- H Processed Amount: Total amount paid on check run

Explanation of Payment Key cont.

- I Any discount or interest applied to the
- J -Net Amount: This column contains payment amount of the claim service line. Unpaid claims will contain a ".00" in this column.
- K Refund Amount: The amount refunded by the health plan .
- L Amount Recouped: The recoupment amount taken by the health plan.
- M Amount Paid: The total amount paid on this check
- N Ending Balance: Remaining negative balance due.
- O EFT Reference: EFT Registry Number.
- P EFT Amount: Total amount paid on that check run.
- Q- Bank Account: The provider's account number.

3200 Highland Avenue, MC F648 Downers Grove, IL 60515

TIN: XXXXXXXXX **NPI:** XXXXXXXXX

please contact the Claims Department at 1-866-329-4701 (TTY:711) or visit our website at

If you have any questions

www.aetnabetterhealth.com/Illinois-medicaid

01/05/2021 Remit Date:

EFT Reference #: XXXXXXXXXXX

Aetna Better Health of Illinois Benefit Plan:

Messages

Aetna Better Health of Illinois offers the following resources for additional information and assistance:

- 1) Claims Inquiry: please call 866-329-4701 (TTY: 711) Opt 3, Monday Friday, 8:30 AM to 5:00PM CT to verify that your claim processed correctly, or for clarification of information. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.
- 2) Revised Claims Resubmission and Reprocessing: A "resubmission" is defined as a claim originally denied because of missing information or incorrect coding that prevents Aetna Better Health from processing the claim. Per Federal regulation 42 CFR § 424.44(a), health care providers must submit a corrected claim within 6 months from the date of service.

Mark at the top of the claim "RESUBMISSION" and include the following:

- Statement indicating the correction or request;
- Copy of the original claim;
- Copy of the remit notice showing the claim denial;
- Documentation supporting request;
- Any additional information required to process the claim;
- 3) To Appeal a Claim Denial:

Attention health care providers not contracted with Actna Better Health directly or through its subcontracted networks: If you do not agree with this decision, you have the right to appeal. An appeal is a review by people independent of the original claim decision. You may submit an appeal for a claim denied based on error or absence of fact, except for timely filing. Federal regulations 42 CFR 42 § 422.504(g) requires us to protect Aetna Better Health members from financial liability, therefore, appeals must include a signed Waiver of Liability (WOL) form, (available at www.aetnabetterhealth.com/Illinois).

To appeal a claim denial, write a letter and mark the top of the request "appeal" and include the following:

- Statement indicating factual or legal basis for appeal;
- _ A signed "Waiver of Liability";
- Copy of the original claim
- Copy of the remit notice showing the claim denial.
- Any additional information, clinical records or documentation

Mail to:

Mail to:

P.O. Box 66545 Phoenix, AZ 85082-6545

Aetna Better Health of Illinois ATTN: Grievance & Appeals P.O. BOX 81040 Cleveland, OH 44181

Aetna Better Health of Illinois

Please note: A dispute reference number will be the adjusted claim number of the initial claim that was disputed. The dispute claim decision will show up on this remittance as the claim number with an addition of two digits (A1 for example).

4) To Appeal a Claim Payment Amount

Attention health care providers not contracted with Aetna Better Health directly or through its subcontracted networks: If you do not agree with the payment amount, you have the right to dispute the payment amount and file an appeal. An appeal is a review by people independent of the original claim decision. You may submit an appeal for a claim payment dispute when you believe that under original Medicare you would have been paid a different amount.

To appeal a claim payment, write a letter and mark the top of the request "appeal" and include the following:

- Statement indicating factual or legal basis for appeal;
- Documentation showing that you would have received a different payment under original Medicare:
- Copy of the original claim
- Copy of the remit notice showing the amount paid

Note: Appeals must be filed within 60 days from the date of this remit

Aetna Better Health of Illinois ATTN: Grievance & Appeals P.O. BOX 81040 Cleveland, OH 44181

Please note: A dispute reference number will be the adjusted claim number of the initial claim that was disputed. The dispute claim decision will show up on this remittance as the claim number with an addition of two digits (A1 for example).

- 5) Providers are encouraged to review our website: www.aetnabetterhealth.com/Illinois for updates to our Provider Manual and provider notifications.
- 6) If you would like to report healthcare fraud related issues please call the toll-free hotline at 1-866-670-6885, contact us by e-mail at aetnasiu@aetna.com, or online at https://www.aetnabetterhealth.com/illinois/fraud-abuse.
- If you are returning the original check issued by Aetna, please mail within 60 days to:

Aetna Better Health of Illinois Attn: FINANCE 4500 E. Cotton Center Blvd.

Please mail a **refund check** for any overpayments or claim processing errors within 60 days to:

Aetna Better Health of Illinois Attn: FINANCE P.O. BOX 842499 Dallas, TX 75284-2499

Proprietary

Phoenix, AZ 85040

284

ENV 10271

COPY

Return Service Requested

ALL FOR AADC 630

10271 0.7130 AB 0.416

իակվովիակակինկինդանկորդիրնդվինրակել

XXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXX Claim Number: Check Number: XXXXXXXX 01/05/2021 Check Date: Check Amount: \$1,653.20

3200 Highland Avenue, MC F648 Downers Grove, IL 60515

PAY One Thousand Six Hundred Fifty Three & 20/100 Dollars ORDER OF PAYMENT MADE ELECTRONICALLY **Bank of America**

Electronic Funds Transfer XXXXXXXX

91-170 1221

EFT REF #: XXXXXXXX **REMIT DATE: 2021/01/05**

AMOUNT

****\$1,653.20

Void After 180 Days



1 OF 1

Return Service Requested

4574 0.0324 ՍուվընդովորվեկըովԱկիդիվԱրդիրիվիդոնկին

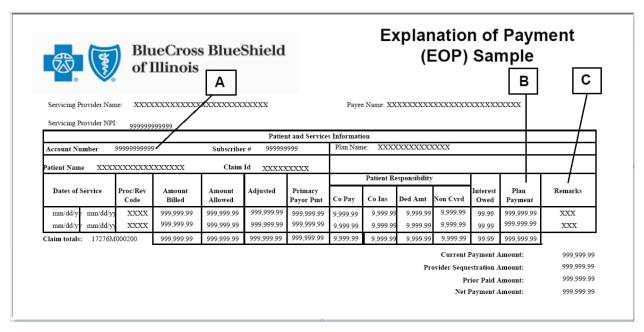
Payee Name: XXXXXXXXXXXXXXXXXXXX

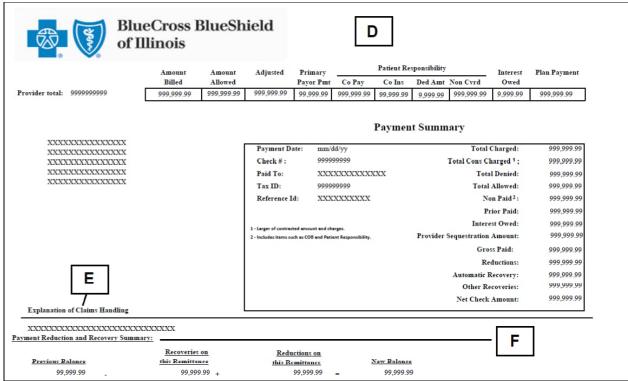
> XXXXXXXXXXXX Payee Bank:

XXXXXXX **ACH Amount:** XXXXXXX **ACH Bank ID:**

ACH Transaction







Negative Balance I	Details:				G	
Creation Date	Reduction Type	Original Claim Information	Original Reduction	Prior Recovery	Current Recovery Current	it Balance
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
		Dates of Service: mm/dd/yy- mm/dd/yy				
		Patient Account #: XXXXXXXXXXXXX				
		Original Claim Control #: XXXXXXXX				
		Original Check #: XXXXX				
		Original Check Date: mm/dd/yy				
		LOB: XXXXXXXXXXXXXXXXX				
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
		Dates of Service: mm/dd/yy- mm/dd/yy				
		Patient Account #: XXXXXXXXXXXXXX				
		Original Claim Control #: XXXXXXXX Original Check #: 99999				
		Original Check Date: mm/dd/yy				
		LOB: XXXXXXXXXXXXXXX				
mm/dd/yy	Manual Reduction	LOD. THE BURGERS AND THE STATE OF THE STATE	9999.99	9999.99	9999.99	9999.99

Explanation of Payment Notes

- A- Account Number: refers to the patient account number.
- B- Plan Payment: refers to the dollar amount paid. Unpaid claims will contain "0.00" in this column.
- C- Remarks: This column contains the codes that describe the reason for how claims were processed or payment denial.
- D- Payment Summary: Totals grouped together by provider.
- E- Explanation of Claims Handling: These descriptions define the meaning of each remark code used in the Explanation of Payment (EOP).
- F- Payment Reduction and Recovery Summary: The summary is a roll-up from G.
- G- Negative Balance Detail: Detail related to recoupment letters that were sent to providers. These amounts remain on the remit until the refund has been collected in full.

County Care Health Plan

EOP Field Definition & Interpretation

Procedure – Code for service rendered.

No. of Units – No. of Units refers to the quantity of a specific service rendered.

COB – Coordination of Benefits indicating a third-party payment

Amount Billed – Total billed charges for an individual claim.

Adjustment/Remark Codes – Contains codes that describe the reason for how claims were processed or payment denial.

Meridian Health - A WellCare Company

Definition of Key Terms

Deductible The amount a member must pay for covered services before MeridianChoice will

pay any expenses. The deductible may not apply to all covered services.

Out-of-Pocket Expenses A member's share of expenses that must be paid directly to the provider and are

not reimbursed by MeridianChoice.

Maximum Annual Amount The maximum amount a member must pay in a benefit year before MeridianChoice

will pay 100% for covered services.

Charges This is the total amount the provider billed for the services provided.

Allowed Amount The amount MeridianChoice has negotiated with providers to pay.

Plan Paid This is the portion of the amount billed that was paid by Meridian Choice

Amount You Owe The portion of the amount billed the member owes to the provider(s). This amount does not reflect any payment you may have already made at the time the member

received services. This amount may include your deductible, copay, coinsurance and/or non-covered charges.

In-Network Expenses Members are responsible to pay copay, deductible and coinsurance amounts for

services provided by an in-network provider.

Out-of-Network Expenses Members may be responsible for full payment of services provided by an out-of-

network provider.

Non-Covered Expenses Members may be held responsible for the full payment of non-covered charges.

Non-covered charges are defined as services not covered under the member

benefit plan or services obtained without authorization.

Excluded Amount Members may be held responsible for the payment of Excluded Services. Excluded

Services are defined as services received by a provider not included in the

MeridianChoice network.

Copayment Is the fixed amount you pay each time you receive certain medical

services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your

copayments.)

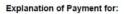
Coinsurance Is the percentage you pay of the total cost of certain medical services.

You pay a coinsurance at the time you get the medical service. (The

Medical Benefits Chart in Section 2 tells you more about your

coinsurance.)

EXPLANATION OF PAYMENT

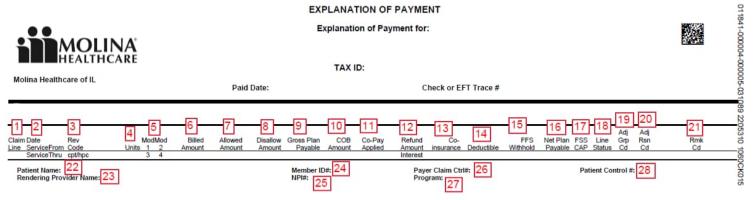




MOLINA HEALTHCARE

TAX ID:

Molina Healthcare of IL Paid Date: Check or EFT Trace #



TOTAL AMOUNT:

***Msg: 29

30	DESCRIPTION OF HIPAA ADJUSTMENT & REMARK
----	--

ADJ GRP CODE	DESCRIPTION
CO	Contractual Obligation
31	
ADJ RSN CODE	DESCRIPTION
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
B1	Non-covered visits.
32	
RMK CODE	DESCRIPTION
N30	Patient ineligible for this service

- 1. Claim Line The claim line number
- Dates of Service The date range for services rendered
- **Rev/CPT/HPC Code** Codes billed per that line
- **Units** Refers to the quantity of a specific service rendered

- 5. Modifier The modifier number added to the code
- 6. Billed Amount—Line billed amount
- 7. Allowed Amount—Contractual allowed amount for the billed service
- 8. Disallow Amount—Amount greater than the allowed amount and not eligible for reimbursement
- 9. Gross Plan Payable—Total amount eligible for reimbursement
- 10. COB Amount—COB dollars applied from primary carrier or Medicare
- 11. Co Pay Applied Member copay amount
- 12. Refund Amount/Interest—Interest paid on the claim
- 13. Co-insurance Applicable member coinsurance
- 14. Deductible Applicable member deductible applied
- **15. FFS Withhold**—2% Federal Mandate reduction amount (applies to MMP only)
- 16. Net Plan Payable—The amount the MCO is paying, less any member liability or COB applied
- 17. FSS CAP—Indicator if claim was paid fee-for-service or a capitated payment
- 18. Line Status—Indicates the line status of paid or denied on professional claim lines
- 19. Adj Group Code -Code identifies a specific pricing arrangement with the provider. Explanation of code can be found at the end of the EOP (30)
- 20. Adj Reason Code—Code identifies a specific reason(s) claim/line payment was denied or reduced. Explanation of code can be found at the end of the FOP (31)
- 21. Remark Code—Code for further explanation of claim adjudication and can be found at the end of the EOP (32)
- 22. Patient Name—Name of patient
- 23. Rendering Provider Name—Rendering provider name
- 24. Member ID #--Recipient ID Number for Medicaid Members, Molina ID number for MMP members
- 25. NPI #--Rendering provider NPI number
- 26. Payer Claim Control # -- MCO claim number
- 27. Program—Line of business (HealthChoice IL or MMP)
- 28. Patient Control #--Provider submitted patient control #
- 29. Message—Special claims process notes are included here and for MMP reminders regarding patient liability
- 30. Adj Group Code/Description—full text description of the group adjustment reason code found in number 19
- 31. Adj Reason Code/Description—full text description of the adjustment reason code found in number 20
- 32. Remark Code/Description—full text description of the remark code found in number 21

Appendix F: Hysterectomy (HFS 1977) and Sterilization (HFS 2189) Memo



All Medicaid MCOs require the HFS 1977 Hysterectomy Acknowledgement form or the Sterilization form 2189.

The appropriate form must be completed fully and accurately prior to a hysterectomy or sterilization being performed on a Medicaid member. A form is not considered complete if it is not signed and dated appropriately by both the member and the physician.

IAMHP and its member plans have prepared a brief summary and highlighted areas where common mistakes are made for the **HFS 1977 form**:

Part I must be completed in its entirety. The provider number is the Medicaid provider ID number. If Part I is not complete a provider may face a claim denial.

Parts II and III must be signed and dated by the patient and physician no later than the date of the surgery. The purpose of the HFS 1977 hysterectomy acknowledgement form is to ensure members are informed of the effects of a hysterectomy prior the surgery. Additionally, the physician signature is needed to ensure appropriate clinical review.

Part IV, if applicable, must be signed and dated in addition to providing the appropriate detail regarding the exception.

IAMHP and its member plans have prepared a brief summary and highlighted areas where common mistakes are made for the **HFS 2189 form:**

Consent to Sterilization must be completed and signed by the Medicaid member prior to treatment. Race and ethnicity information is requested but not required.

Interpreter statement must be completed and signed if an interpreter was used. The date should be prior to treatment.

Statement of person obtaining consent must be completed and signed prior to treatment. If the information is completed but there is not a signature the form is not complete. The signature may not be provided at a later date.

Physician statement must be completed and signed prior to treatment. Additionally, please **cross out** paragraph 1 or 2, whichever is **NOT** used. If a physician circles a section that is used the form has not been completed accurately. If the information is completed but there is not a signature the form is not complete. The signature may not be provided at a later date.

HFS 1977 Hysterectomy Acknowledgement Form

Helpful Hints_Form Must Be Completed In Its Entirety



State of Illinois

Department of Healthcare and Family Services

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

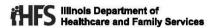
PAR	T I - (MUST BE COMPLETED)	
Recip	pient Name	
Recip	pient Identification No.	Provider No.
Phys	ician Name	NPI No.
PAR	TII - ACKNOWLEDGEMENT	
and t	s been explained to the patient's representative, if any, orally and in ender the patient permanently incapable of rep	n writing that the hysterectomy to be performed on the patient producing.
Recip	pient or Representative Signature	Date:
(If red	quired, Interpreter Signature)	Date:
PAR	T III - PHYSICIAN STATEMENT	
	y professional judgment, the hysterectomy is normed for other medically necessary reasons.	ot being performed solely to accomplish sterilization; it is being
Phys	sician Signature	Date:
PAR	T IV - EXCEPTION REQUEST	
	Exception 1 - I certify that the above named The cause of the sterility was	individual was already sterile at the time of the hysterectomy.
	Exception 2 - I certify that the hysterectomy under a life threatening emergency situation i.e.	performed on the above named individual was performed
	in which I determined prior acknowledgmen	t of receipt of hysterectomy information was not possible. I have cord or other written explanation as to the nature of the
•	Exception 3 - The above named individual h Medicaid eligibility. Date of Surgery	ad a hysterectomy performed during a period of retroactive
the p	ify that the above named individual was information to the above attent permanently incapable of reproducing; a criffied above, made such explanation unneces	
Phys	sician Signature	Date:
		ILCS 5/1-1 et seq., penalty non-payment. the Forms Management Center.
HFS	1977(R-12-09)	

Part I MUST be completed in its entirety or is subject to a claim denial. (The Provider No. is the Provider's Medicaid ID #.)

Part IV – Please fill out as applicable, sign and date

Sterilization Form 2189 Provider Tip Sheet

This form must be completed in its entirety or will be subject to a claim denial. Please remember to choose and complete fields (1) or (2) under the Physician's Statement. Without completing, the claim will be subject to a claim denial.



NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■	■ STATEMENT OF PERSON OBTAINING CONSENT ■		
I have asked for and received information about sterilization from	Before signed the consent Name of Individual		
When I first asked for the (doctor or clinic)	form, I explained to him/her the nature of the sterilization operation		
information, I was told that the decision to be sterilized is completely up	, the fact that it is intended to be a final and		
to me. I was told that I could decide not to be sterilized. If I decide not	irreversible procedure and the discomforts, risks and benefits associated		
to be sterilized, my decision will not affect my right to future care or	with it.		
treatment. I will not lose any help or benefits from programs receiving	counseled the individual to be sterilized that alternative methods of		
Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for	birth control are available which are temporary, I explained that		
which I may become eligible.	sterilization is different because it is permanent.		
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED	I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health benefits		
PERMANENT AND NOT REVERSIBLE, I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER	provided by Federal funds.		
CHILDREN.	To the best of my knowledge and belief the individual to be sterilized is		
I was told about those temporary methods of birth control that are	at least 21 years old and appears mentally competent. He/She		
available and could be provided to me which will allow me to bear or	knowingly and voluntarily requested to be sterilized and appears to		
father a child in the future. I have rejected these alternatives and	understand the nature and consequence of the procedure.		
chosen to be sterilized.			
I understand that I will be sterilized by an operation known as a	Signature of person obtaining consent Date		
 *	Signature of person obtaining consent Date		
The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my			
satisfaction.	Facility		
I understand that the operation will not be done until at least thirty days			
after I sign this form, I understand that I can change my mind at any	Address		
time and that my decision at any time not to be sterilized will not result in	Address		
the withholding of any benefits or medical services provided by federally	■ PHYSICIAN'S STATEMENT		
funded programs.	Completion Mandatory, 305 ILCS 5/1-1 et seq., penalty non-payment.		
I am at least 21 years of age and was born on	Shortly before I performed a sterilization operation upon		
Month Day Year	, on,		
I, hereby consent of my own free will to be sterilized by	Name of individual to be sterilized Date of sterilization operation		
ing own not will to be sternicou by	explained to him/her the nature of the sterilization operation, the fact that it is intended to be a final		
(Doctor)	Specify type of operation		
by a method called My	and irreversible procedure and the discomforts, risks and benefits		
consent expires 180 days from the date of my signature below.	associated with it. I counseled the individual to be sterilized that		
I also consent to the release of this form and other medical records	alternative methods of birth control are available which are temporary.		
about the operation to:	explained that sterilization is different because it is permanent.		
Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only	I informed the individual to be sterilized that his/her consent can be		
for determining if Federal laws were observed	withdrawn at any time and that he/she will not lose any health services		
I have received a copy of this form.	or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears		
Date	mentally competent. He/She knowingly and voluntarily requested to be		
Signature Month Day Year	sterilized and appears to understand the nature and consequence of the		
You are requested to supply the following information, but it is not	procedure. (Instructions for use of atternative final paragraphs: Use the		
required:	first paragraph below except in the case of premature delivery or		
Race and ethnicity designation (please check) American Indian or Black (not of Hispanic origin)	emergency abdominal surgery where the sterilization is performed less		
Alaska Native Hispanic	than 30 days after the date of the individual's signature on the consent		
Asian or Pacific Islander White (not of Hispanic origin)	form. In those cases, the second paragraph below must be used. Cross		
Asian of Facilic Islander Tithite (not of hispanic origin)	out the paragraph which is not used.) (1) At least 30 days have passed between the date of the individual's		
■ INTERPRETER'S STATEMENT ■	signature on this consent form and the date the sterilization was		
If an interpreter is provided to assist the individual to be sterilized:	performed		
I have translated the information and advice presented orally to the	(2) This sterilization was performed less than 30 days but more than 72		
individual to be sterilized by the person obtaining this consent. I have	hours after the date of the individual signature on this consent form		
also read him/her the consent form in	because of the following circumstances (check applicable box and		
language and explained its contents to him/her. To the best of my	fill in information requested):		
knowledge and belief he/she understood this explanation.	Premature delivery		
	Individual's expected date of delivery:		
	☐ Emergency abdominal surgery:		
	(describe circumstances):		
Interpreter Date			
posate • octocoro			
	Physician Date		
HES 2189 (R-7.06)	II 478_1071		

Completion of this form or compliance with instructions is voluntary, however, failure to do so may affect this Department's action. Form approved by Forms Management Center.

Appendix G: Ordering, Referring, Prescribing (ORP)- National Provider Identifier (NPI) Requirements

Effective January 1, 2020, HFS will be implementing new requirements for ordering, referring and prescribing National Provider Identifiers (NPI) for medical and pharmacy claims. These requirements will require MCOs to follow the same HFS rules.

To comply with the Improper Payments Information Act of 2002, the federal Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) has implemented a Payment Error Rate Measurement (PERM) program, which measures improper payments within each state's Medicaid and Children's Health Insurance Program (CHIP) program.

Each state is required to participate in PERM every three (3) years. This change to ORP relates to a PERM audit performed by CMS for FFY 2015 PERM Review. The results of the audit were sent as a Provider Bulletin by HFS on 2/15/2018:

https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn180215a.aspx

HFS issued a provider notice to Participating Medical Assistance Program (MAP) Providers with more details on 11/9/2018:

https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn181109c.aspx

After several delays, HFS announced that implementation of the ORP rule would begin 1/1/2020:

https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn191031a.aspx

These requirements apply to Medicare-Medicaid Alignment Initiative (MMAI) member claims as well as HealthChoice of Illinois member claims.

A. Requirements for Hospice, Ambulatory Surgical Treatment Centers and Hospitals Billing on the UB04/837I

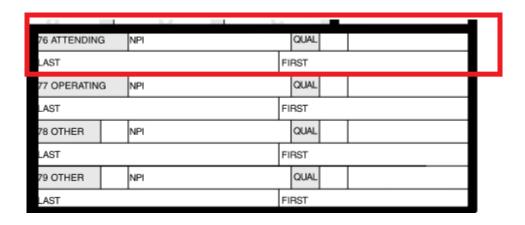
Attending Provider NPI (2310A Loop, Qualifier 71, NM109/FL 76 on UB-04) is required for **all** institutional claims (with the exception of SUPR institutional claims) and HFS already edits claims to ensure the Attending Provider NPI field is valid. As of January 1, 2020, HFS will require that the Attending Provider be actively enrolled as an individual provider in IMPACT for HFS provider types as follows:

HFS Provider Type Code	Description
30	General Hospitals
31	Psychiatric Hospitals
32	Rehabilitation Hospitals
39	Hospice
46	Ambulatory Surgical Treatment Centers

HFS will use 2310A (Attending Provider – Qualifier 71) and 2310F (Referring Provider – Qualifier DN) loops for NPI validation.

Additionally, if a **Referring Provider** (2310F Loop Qualifier DN/ FL 78 of UB-04) **is present** on the claim, HFS will validate this field. This field is **only** required on outpatient claims (except when Emergency Codes 0450, 0451, or 0456 are present) when the referring Provider is **different** than the Attending Provider. If the Referring and Attending are the same provider, DO NOT include the information in Loop 2310F or FL 78 of the UB-04.

NOTE: Effective 1/1/2022, claims received from HFS Provider Type 50 - Home Health will be adjudicated in the same manner as Hospice, Ambulatory Surgery Centers and Hospitals with regard to ORP logic. Therefore, if the Attending and Referring Providers are the same, DO NOT include the information in Loop 2310F or FL 78 of the UB-04.



HFS Provider Bulletins for reference:

https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn190718a.aspx https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn190718b.aspx https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn190718c.aspx MCOs will validate that the provider's NPI in Box 76 on the UB-04 or 2310A (Attending Provider -71 qualifier in 837) or 2310F (Referring- DN qualifier in 837) loops in the 837I is valid in the IMPACT file.

MCOs' claim systems will generate edits based on the following scenarios

- 1) Ensure the NPI for the loops or Box 76 are present and in proper order for an NPI, if not proper or missing: generate edit = Missing or Invalid Attending Provider NPI. This is always required per HFS on 837I claims.
- 2) NPI is present and passes the NPI check in number 1 but the NPI does not crosswalk to an active enrollment state in IMPACT: generate edit- Attending Provider NPI Not Enrolled
- 3) The NPI is present and passes the NPI check in number 1 but the NPI is not for an individual provider. If the NPI does not crosswalk to an individual (HFS Provider Type 010, 011, 012, 013,016 or 089): generate edit- Attending NPI Not for Individuals

MCO will generate in the same manner and edit if on the 2310F Referring Provider Loop ('DN' Qualifier):

- 1) NPI is present but the NPI does not crosswalk to an active enrollment state in IMPACT: generate edit Referring NPI Not Enrolled
- 2) The NPI is present and passes the NPI check in number 1 but the NPI is not for an individual provider type. If the NPI does not crosswalk to an individual (HFS Provider Type 010, 011, 012, 013,016 or 089): generate edit- Referring NPI Not for Individual.

B. Requirements for Provider Types Billing on the CMS1500/837P

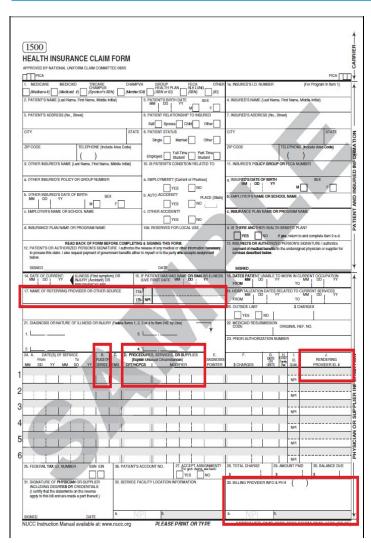
MCOs will use Box 17A for NPI validation from the CMS 1500 paper format. Additionally, the MCOs will use 2310A (Referring – Qualifier DN) and 2420E (Ordering-Qualifier DK) loops for NPI validation via the 837P for certain scenarios (defined later in this section).

Additionally, there will be dependencies on the data billed in the following claim fields/Loops:

- Box 24D- Procedure, Services or Supplies (2400 Loop SV101)
- Box 24B- Place of Service (Loop 2400 SV105)
- Box 24J- Rendering Provider ID (Loop 2310B Rendering Loop)
- Box 33- Billing Provider Info (Loop 2010AA Billing Loop)

Following the National Uniform Claim Committee (NUCC) guidance on the CMS1500 format, the following fields are the standards for Box 17 and other key fields that are considered for ORP billing.

http://www.nucc.org/images/stories/PDF/1500_claim_form_map_to_837P_v3-3_2012_02.pdf



MCOs will validate that the provider's NPI in 17A on paper claims or 2310A (Referring- DN qualifier in 837) or 2420E (Ordering-DK qualifier in 837) loops in the 837P is valid in the IMPACT file.

Define the ORP Relationship is required as follows on the CMS 1500/837P:

The state's guidance indicates the following from the 11/9/18 HFS notice in Table 1 below.

Note: This notice omitted the fact that this applies to **any provider** billing E&M consultations, not just Optometrist or Podiatrist, when the patient resides in a Skilled Nursing Facility (31), Nursing Facility (32) or Custodial Care Facility (33). Services billed in these places must report with the proper place of **service** in Box 24B of the CMS 1500.

Effective 1/1/2022, claims received from Provider Type 50 - Home Health Providers will follow the guidance outlined in Section A.

Table 1

The ORP is required when a practitioner evaluation	uates a participant with respect to a diagnosis or treatment at the		
request of another practitioner (referring) when the following providers bill a consultation code:			
Physician	Advanced Practice Nurse		
• FQHC, ERC, RHC	Podiatrist		
	The ORP is required when the service is rendered in a long term care facility and the Place of Service Code is 31, 32, or 33 when billed by the following providers: SEE NOTE ABOVE		
Optometrist (required when a	Podiatrist		
consultation and procedure code is			
between 99201-99499)			
The ORP is required on all claims for the follo	wing providers:		
Physical Therapist	Hospital Billing fee-for-service		
Occupational Therapist	Durable Medical Equipment and Supplies		
Speech Pathologist	Independent Diagnostic Testing Facilities		
Audiologist	Independent Laboratory		
LEA (when billing OT, PT, Speech,	Imaging: Portable X-ray		
Audiology)	Imaging Centers		
Home Health Agency	Optical Supply Companies		
Community Health Agency	Certified Health Department		
Home Nursing Agency			

Following the direction above, the ORP provider in Box 17 will be validated per Provider Types Billing on the CMS1500/837P ORP Requirements based on the following grid based on the HFS provider type as found first in 2310B Rendering Loop (if present) and then will default to 2010AA Billing Loop to determine

HFS Provider Type, as well as the following data on the claim:

- Box 24B- Place of Service on the paper form (Loop 2400 SV105)
- Box 24D- Procedure, Services or Supplies on the paper form (2400 Loop SV101)

Box 17 required with the following provider types and procedure codes for 'consultations'

HFS Provider	Procedure Codes	Place of Service *	
010 Physicians	Consult codes are:	99241-99245	
040 Federally Qualified Health Centers (FQHC)	99241-99245	In the CPT book, these are	
048 Rural Health Clinics		defined as	
016 Nurse Practitioners		office/outpatient codes.	
043 Encounter Rate Clinics (ERC)		Example: 11, 22, 23 etc.	
013 Podiatrists			
012 Optometrists	99251 – 99255	99251- 99255	
089 Physician Assistant		In the CPT book, these are	
		defined as inpatient codes	
		Example: 21	

^{*}Consult the HFS crosswalk of taxonomies with COS, PC and POS that is available here.

Box 17 required with the following provider types with the following procedure codes for member is in Long Term Care facility:

HFS Provider	Procedure Codes	Place of Service
012 Optometrists	99201 - 99499	31, 32 or 33
013 Podiatrist	ALL	31, 32 or 33

Box 17 is required for all the following HFS provider types in the following scenarios:

HFS Provider	Procedure Codes	Place of Service
022 Physical Therapists	ALL	ALL
023 Occupational Therapists	ALL	ALL
024 Speech Therapists	ALL	ALL
025 Audiologists	ALL	ALL
	Only and an found on the	
051 Community Health Agencies	Only codes found on the HFS Therapy Fee Schedule	ALL
052 Local Health Department	Only codes found on the HFS Therapy Fee Schedule	ALL
30 Hospital31 Psych32 Rehab		
When a hospital is billing an allowable fee for service (NON-APL) billing guidelines on the 837P claim format for dates of service prior to 7/1/2020.	ALL	ALL
For dates of service on or after 7/1/2020, HFS changed the claim format for these provider types to bill on the UB format as a result, these providers should follow the specification in Section A of this appendix.		
061 Independent Laboratories	ALL	ALL
062 Opticians/Optical Companies	ALL	ALL
063 Other Providers of Medical Equipment/Supplies	ALL	ALL
064 Imaging Services	ALL	ALL
065 Independent Diagnostic Testing Facilities/ Independent Diagnostic Testing Facility (IDTF)	ALL	ALL

Provider type 047 Local Education Agencies (LEA) do not apply to MCOs. Only FFS Medicaid handles this requirement. No action needed by MCOs on provider type 047, an excluded provider type from MCO contractual obligations.

C. Pharmacy ORP Requirements

MCO Pharmacy claims will no longer allow prescriptions from non-registered prescribers.

Effective January 1, 2020, Prescriptions Denied if Provider is Not Registered with IMPACT.

As mentioned in the <u>Dec. 28, 2018, provider notice</u>, the Illinois Department of Healthcare and Family Services (HFS) is requiring all ordering or referring physicians or other professionals (ORP) to enroll in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system.

Effective with claim receipt dates or dates of service beginning January 1, 2020, MCOs will reject pharmacy claims submitted through the pharmacy point-of-sale system if the prescribing practitioner identified on the pharmacy claim is not enrolled in the IMPACT system.

It's imperative that all providers responsible for writing a prescription for a Medicaid member is registered and approved in IMPACT by January 1, 2020. For more information, see the <u>provider notice</u> on the HFS website or call the Bureau of Professional and Ancillary Services at 877-782-5565.

Appendix H: MCO Recoupment Letters

Aetna Better Health of Illinois	Pages 304-305
Blue Cross Community Health Plans	Pages 306-308
County Care Health Plan	Page 309
MeridianHealth Page 310-311	
Molina HealthCare	Pages 312-313

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Aetna Better Health of Illinois Attn: Recovery P.O Box 66545 Phoenix, AZ 85082

2/25/2021

Provider Name:

Address:

Attn: Accounts Payable

To ensure that both Aenta Better Health of Illinois and our network of providers remain compliant with Federal and State rules regarding the identification and return of overpayments we regularly review claims data to ensure payment accuracy. During a recent claims review we have identified overpayments outlined in the attached spreadsheet.

We request that the above overpayment be satisfied within the next 60 business days through one of the following methods:

- 1. Submit a refund check for the overpayment amount to the below address within 60 business days of this letter. Please include a copy of this letter with your payment.
- 2. Contact the Claims Inquiry Claims Research Department to approve the overpayment offset to begin from future payments prior to the 60 business day deadline.

If we do not receive one of the above responses to this request within 60 business days, the overpayment will be offset with future funds.

Aetan Better Health of Illinois - Finance PO Box 842499 Dallas, TX 75284-2499

If you believe you received this letter in error or have any pertinent information that may not have been considered in making this determination, please contact our Claims Inquiry Claims Research (CICR) Department at (866)-600-2139 Monday through Friday 8:00 a.m. to 5:00 p.m. CST.

Per Illinois state law, Aetna Better Health of Illinois is obligated to notify you of your dispute rights. If you would like to submit a provider dispute, please submit a request to:

Aetna Better Health of Illinois

Provider Dispute Resolution 3200 Highland Ave MC F68 Downers Grove, IL 60615

This dispute request must include the following information:

- 1. Name, address and phone number of the rendering provider.
- 2. Aetna Better Health of Illinois individual provider identification number, if applicable.
- 3. A complete and accurate explanation of the issue.
- 4. Supporting documentation including copies of claims (if applicable), claim number, medical records or

supporting documentation to challenge the initial adverse determination and a copy of this letter.

Aetns Better Health of Illinois will process your dispute request within 60 working business days.

If you do not contest this overpayment determination within 60 working-business days, Aetna Better Health of Illinois will offset the amount(s) on the future remittance advice.

We apologize for any inconvenience this may have caused you and thank you for your prompt attention in resolving this matter.

Thank you,

Claims Department

Overpayment Reason Key:

O ver payment reason in	.ey.
CR Log#	CR Log Description



[LETTER_GEN_DT]

[PRPR_NAME]
[PRPR_ADDR1]
[PRPR_ADDR2]
[PRPR_ADDR3]
[PRPR_CITY], [PRPR_STATE] [PRPR_ZIP]

NPI: [PRPR_NPI]

Payee: [PRPR_NAME]

Patient Name: [MEME_LAST_NAME], [MEME_FIRST_NAME]

Participant ID #: [SBSB_ID]

Group #: [GRGR_ID]

Claim #: [ORIG_CLCL_ID]

Date(s) of service: [CDML_FROM_DT] to [CDML_TO_DT]

Patient Account #: [CLCL_PA_ACCT_NO]

Total charges: \$ [CLCL_TOT_CHG]
Previous payment: \$[CLCK_NET_AMT]
Correct payment: \$ [CLCL_TOT_PAYABLE]

Overpayment: \$[RECOUP_AMT]

Prior recoveries/refunds received: \$[ACPR_RECD_AMT]

Amount Due: \$ [RECOUP_AMOUNT_DUE]

Dear [PRPR_NAME]:

Thank you for providing services to a Blue Cross Community MMAI (Medicare-Medicaid Plan)SM or Blue Cross Community Health Plan (BCCHP) member. Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to providing quality service for members enrolled in these products, and therefore, we periodically review the accuracy of previously paid claims. This review identified an overpayment of previously paid benefits for the account above.

The reason for this overpayment is:

[RECOUP_REASON]

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



The amount due may be paid by check and should be submitted within 90 days. To ensure that you are properly credited for the refund, please complete the attached form and mail it along with your check, made payable to Blue Cross and Blue Shield of Illinois. If payment is not received within 90 days, BCBSIL will recoup funds from future claim payments, if applicable.

All payments should be sent along with a copy of this letter to:

Health Care Services Corp Claims Overpayment Dept CH 14212 Palatine, IL 60055-1290

If you need additional information regarding the overpayment, please contact us at the following: MMAI: 877-723-7702 or BCCHP: 877-860-2837. Monday – Friday between 8 a.m. and 8 p.m. Central Standard Time (CST), except holidays. Please remember that the recoupment process will begin in 90 days if payment or correspondence is not received from you.

Claims Dispute Process:

If you disagree with the billing determination, requested reimbursement amount, or if you have a contract dispute, you may submit a provider dispute by calling us at:

BCCHP: 877-860-2837 MMAI: 877-723-7702

Please have the following information ready when calling for a claims dispute; the patient name, the service date, provider name, tax identification number or national identification number, description of dispute and whether this is a single dispute or a multiple claims dispute.

Sincerely,

Blue Cross and Blue Shield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



[LETTER_GEN_DT]

	****** REMITTANCE FORM ******
Attention:	Health Care Services Corp Claims Overpayment Dept CH 14212 Palatine, IL 60055-1290
Remitters Name:	[PRPR_NAME] [PRPR_ADDR1] [PRPR_ADDR2] [PRPR_ADDR3] [PRPR_CITY], [PRPR_STATE] [PRPR_ZIP]
Participants Name:	[MEME_LAST_NAME], [MEME_FIRST_NAME] r: [GRGR_ID] and [SBSB_ID]
droup and 1D ivalliber	. [drdr_ib] and [sbsb_ib]
Claim Number:	[ORIG_CLCL_ID]
Amount Requested:	\$[RECOUP_AMOUNT_DUE]
Amount Remitted:	\$
If the amount remitted	d is different from the amount requested, please explain:
Signature:	Telephone Number:

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

PAYMENT COUPON - PLEASE RETURN TH	IS WITH YOUR REFUND CHECK
PAYEE NAME: [Provider]	REFUND CHECK AMOUNT:
TAX ID NUMBER: [TIN]	REFUND CHECK NUMBER:
ADDRESS: [Address]	
PROVIDER NAME: [Provider]	
PATIENT ACCOUNT NUMBER: [Acct #]	
SERVICE DESCRIPTION: [HIGH LEVEL SERVICE]	
OVERPAYMENT REASON: [Query Description]	

Claim number	Member Name	Medicaid Number	Paid Date	Date of Service	<u>Billed</u>	<u>Paid</u>	Overpayment
[CI#]	[Pt Name]	[Medicaid #]	[Paid Date]	[Admit-Disch]	\$[Total Charges]	\$[Paid]	\$[Refund Amount]

<NAME>
<ADDRESS LINE 1> <ADDRESS LINE 2>
<CITY> <STATE> <ZIP>

<DATE>

Dear Provider,

Please be advised that Meridian completed a review of outstanding claims and identified an overpayment for the group and/or provider as revealed on the attached sheet(s). Overpayments may occur for a variety of reasons, including, but not limited to, changes in membership due to retroactive or late eligibility adjustments, changes to a provider's Illinois Medicaid Program Advanced Cloud Technology (IMPACT) registration or status (if Medicaid), rate changes or updates, application of retroactive fee schedule adjustments, or policy changes issued by the Illinois Department of Healthcare and Family Services (HFS) for Medicaid or the Centers for Medicare and Medicaid Services (CMS).

This overpayment may be settled by submitting refund checks to the health plan. If a full refund is not received within 60 days of the date of this notice, the health plan will conduct the collection of the total refund amount through recoupment and reduction of future claim payments.

Please send a refund check in the amount listed on the next page, on behalf of the provider listed, to the address below:

Meridian
Attn: Finance Department
1 Campus Martius, Suite 700
Detroit, MI 48226

Please include a copy of this letter, along with your check, in order for your account to be properly credited.

If you disagree with these findings:

• You may file a dispute within 120 days of the date of the recoupment remittance advice by mail at:

Meridian

Attn: Payment Integrity, Recovery Team 1 Campus Martius, Suite 710 Detroit, MI 48226

• Or, online at:

www.mhplan.com located under **Our Plans > Illinois > Provider S > Provider Resources > Documents** and Forms > Request for Claim Dispute Form.

Sincerely,

Meridian

Provider Name: < Provider Name >

Provider ID (and TIN): <ProviderID>

Member Name: < Member Name>

Plan Name: <PlanName>

Member ID (RIN and Meridian ID): < MemberID>

Claim #: <ClaimNumber>

Date of Service: <DOS>

Service code/description (for overpaid claim/claim line) : <ServiceCode>

Reason for recoupment: <Reasoning>

Recoupment amount: <DollarAmount>



Page 1 of 2

3/25/2019

HAMILTON MEMORIAL HOSPITAL PO BOX 429 MC LEANSBORO, IL 62859

Re: Overpayment

Dear Provider:

During a recent audit of claim(s) payment we noted an overpayment was issued on the account(s) below referenced.

Claim Number: 18347375835 **Billed Amount:** \$258.30 **Patient Name:** MARTIN, LISA **Paid Amount:** \$17.03 Account No: 619021XX001XH2 **Paid Date:** 12/17/2018 Date(s) of Svc: 11/30/2018 - 11/30/2018 **Check Number:** EFT850080 PayNetWithhold: \$17.03 FFS withhold: \$0.00

Overpayment Reason: Incorrect code billed for services

Amount Overpaid: \$17.03

Comments: Per edit review, it is found that the medical records do not support global payment of

71046 on line 1 on claim # 183473758535. The professional component was rendered by another provider.. Global reporting of a service that has professional and technical components is not appropriate when one of those components is rendered by another

provider.

Claims Specialist: Della W Phone: 866-642-8999,

Claim Number: **Billed Amount:** \$306.60 18348161141 **Patient Name:** JENNY, CHASITY **Paid Amount:** \$27.93 Account No: 619289XX001XH2 Paid Date: 12/17/2018 Date(s) of Svc: 12/05/2018 - 12/05/2018 **Check Number:** EFT850080 PayNetWithhold: FFS withhold: \$27.93 \$0.00

Overpayment Reason: Incorrect code billed for services

Amount Overpaid: \$27.93

Comments: Per edit review, it is found that the medical records do not support global payment of

72100 on claim # 18348161141. The professional component was rendered by another provider. Global reporting of a service that has professional and technical components is not appropriate when one of those components is rendered by another provider.

Claims Specialist: Becky T Phone: 866-642-8999,

Provider Name : HAMILTON MEMORIAL HOSPITAL Letter Date : 3/25/2019



Claim Number: 18358155583 **Billed Amount:** \$780.15 Patient Name: SAVAGE, PAYTON **Paid Amount:** \$34.26 Account No: 619317XX001XH2 Paid Date: 12/26/2018 Date(s) of Svc: 12/05/2018 - 12/05/2018 **Check Number:** EFT858387 PayNetWithhold: FFS withhold: \$34.26 \$0.00

Overpayment Reason: Incorrect code billed for services

Amount Overpaid: \$18.59

Comments: Per edit review, it is found that the medical records do not support global payment of

74019 on claim # 18358155583. The professional component was rendered by another provider. Global reporting of a service that has professional and technical components is not appropriate when one of those components is rendered by another provider.

Claims Specialist: Becky T Phone: 866-642-8999,

We respectfully request a refund or written notice that you wish to contest this refund request within 60 days of this notice.

If payment is not received within 60 days or according to your contract, Molina Healthcare of IL reserves the right to deduct any outstanding balance on future claims payment. Any retraction activity will appear on your Remittance Advice. To avoid any retraction, please send the refund accompanied with this letter to:

Molina Healthcare of Illinois Bin 88826 Milwaukee, WI 53288-0826

A written notice that you wish to contest this refund should be sent within 60 days of this notice to the fax number below or mailed to:

Molina Healthcare of Illinois P.O. Box 2470 Spokane, WA 99210-2470

If you prefer the overpayment(s) to be deducted from a future remittance(s), please sign below and fax to 855-260-8740

I agree to have the above claim(s) adjusted, please deduct the overpaid amount(s) from future claims payments.

Approval Signature/Title	Date	

If your refund has already been sent, please disregard this notice. Thank you in advance for your attention in this matter. If you have questions, please feel free to contact the specialist listed above.

Respectfully

Corporate Claims Recovery

Provider Name : HAMILTON MEMORIAL HOSPITAL Letter Date : 3/25/2019

Molina Healthcare of Illinois, 1520 Kensington Road, Oak Brook, IL, 60523

Administrative Days Reimbursement Implementation

Effective with dates of service on or after July 1, 2019, MCOs will provide reimbursement for inpatient stays extended beyond medical necessity ("Administrative Days") for HealthChoice Illinois <u>and MMAI</u> members due to the inability of the member's MCO or the hospital discharge planner to find an appropriate post-discharge placement

Administrative Days (ADs) are inpatient stay days for members who no longer require acute hospital care, but discharge to a sub-acute or post-acute setting has proven problematic due to the unique circumstances of these members. It is expected that the facility will know the impediments to placement early in the patient's stay and begin working collaboratively with the member's MCO on discharge planning as soon as possible.

Criteria for ADs

Discharge planning is a partnership between hospitals and MCOs, and both parties should work collaboratively to identify any barriers to post-discharge placement as soon as possible upon admission.

Coverage Criteria:

- The member is covered by Medicaid and was initially admitted with a diagnosed condition that required an acute inpatient level of care, either medical or psychiatric care.
- The provider notifies the MCO of an initial member admission within 24 hours.
- The initial admission was authorized by the MCO.
- The member
 - o no longer meets medical necessity criteria for inpatient acute care;
 - there is a specific and documented discharge plan in place to a lower level of care;
 - o however, documented barriers to implementation of the discharge plan exist that are beyond the control of the provider, facility and the MCO.
- The facility notifies the MCO as soon as they believe post-discharge placement will be difficult so the MCO can collaborate on discharge placement and the hospital can obtain authorization number to ensure proper payment.
- If MCO is notified of admission and has information that indicates member could be difficult to place, the MCO will communicate and work with facility to find placement.
- The provider or facility has made reasonable and documented efforts to engage the MCO in discharge planning and has identified substantial barriers to discharge in advance of the discharge date.

Exclusionary Criteria:

- The member has met his/her individualized discharge criteria and substantial barriers to discharge no longer exist. ADs do not replace any or all non-covered days past medical necessity unless Coverage Criteria above are met.
- The inpatient facility is pursuing a discharge to a level of care or service that a MCO has
 explicitly stated is not a Medicaid covered benefit, and/or the member does not meet

- clinical criteria for the intended placement, and the facility has not worked with the MCO to identify alternative and appropriate placements.
- Health Plans are not responsible for administrative days that are the responsibility of DCFS.

Billing requirements for ADs

For dates of service on or after 7/1/2019, ADs will need to be billed on an UB04/837I Institutional Claim format. The facility will submit two claims to the MCO:

- <u>Claim 1:</u> Regular inpatient claim following billing guidelines per the inpatient section of the IAMHP Comprehensive Billing Guide. Facility is to use Bill Type 111 and Discharge Status Code (DSC) 95. This is the claim for the inpatient stay and is distinct from the Administrative Days' stay/admission.
- <u>Claim 2:</u> Inpatient claim for Administrative Days only, using revenue code 0169 for room and board charges only. *Ancillary codes/services should not be billed on this second claim* and will not be payable by an MCO while the member is awaiting placement. Claims containing a mixture of administrative days and any other revenue code will be denied. Facilities will use Bill Type 111 for AD stays under 30 days.
- Since the second claim is reimbursable at a per diem rate, when the member remains in
 administrative day status over 30 days the standard HFS rules for Interim Claims will apply.
 As noted in the IAMHP Comprehensive Billing Guide, interim claims for inpatient services
 rendered and paid by the per diem reimbursement methodology cannot be split unless the
 stay exceeds 30 days or the patient is transferred to another facility or category of service.

• Billing Scenarios:

Scenario One:

IP psych admission (Jan 1-21) Claim 1: BT 111 with DSC of 95

AD Stay for 6 days (Jan 22-28) Claim 2: BT 111 with DSC XX (whatever is

appropriate)

Scenario Two:

IP psych admission 14 days (Jan 10-24) Claim 1: BT 111 with DSC of 95

AD stay for 45 days (Jan 25-Mar 3) Claim 2: BT 112 with DSCof 30 (Jan 25-31)

BT 113 with DSC of 30 (Feb 1-28) BT 114 with DSC of XX (Mar 1-3)

BT 114 WITH DSC of XX (Mar 1-3)

Scenario Three: *

IP psych admission 20 days (Jan 1-20) Claim 1: BT 111 with DSC of 95

AD stay for 30 days (Jan 21-Feb 20) Claim 2: BT 112 with DSC of 30 (Jan 21-31)

Claim 3: BT 114 with DS of XX (Feb 1-20)

^{*}See UB-04 examples at the end of this Appendix

Scenario Four:

IP Medical Admission 45 days (Jan 1-Feb 14) Claim 1: BT 111 with DSC of 95 (Jan 1-Feb 14) AD stay for 60 days (Feb 15 – Apr 16) Claim 2: BT 112 with DSC of 30 (Feb 15-28)

BT 113 with DS of 30 (Mar 1-31) BT 114 with DS of XX (Apr 1-16)

Reimbursement rate for ADs.

Effective 7/1/2019, HFS will require the MCOs to reimburse for ADs when correctly authorized and documented. MHVA, MPA or any other add-on payments do not apply to ADs per legislative mandate.

MCO/FFS Coverage Changes

This guidance applies when coverage changes during an Administrative Day, from FFS to/from an MCO or from MCO to MCO.

HFS-MCO Contracts (MCO to MCO Changes)

Effective Enrollment Date for Hospital ADs:

If an Enrollee is receiving hospital long term care services (ADs), as defined at 89 III. Adm. Code 148.50(c), on the Effective Enrollment Date, Contractor shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. Hospital notification to a Contractor of an admission within 24 hours is not required for reimbursement when the Effective Enrollment Date occurs after that initial 24-hour period described in 305 ILCS 5/14-13.

<u>Charges for MCO Patients Whose Coverage Begins or Ends during a Hospital Long Term Care</u> <u>Day</u>

MCO Coverage Beginning During Hospital Long Term Care Stay

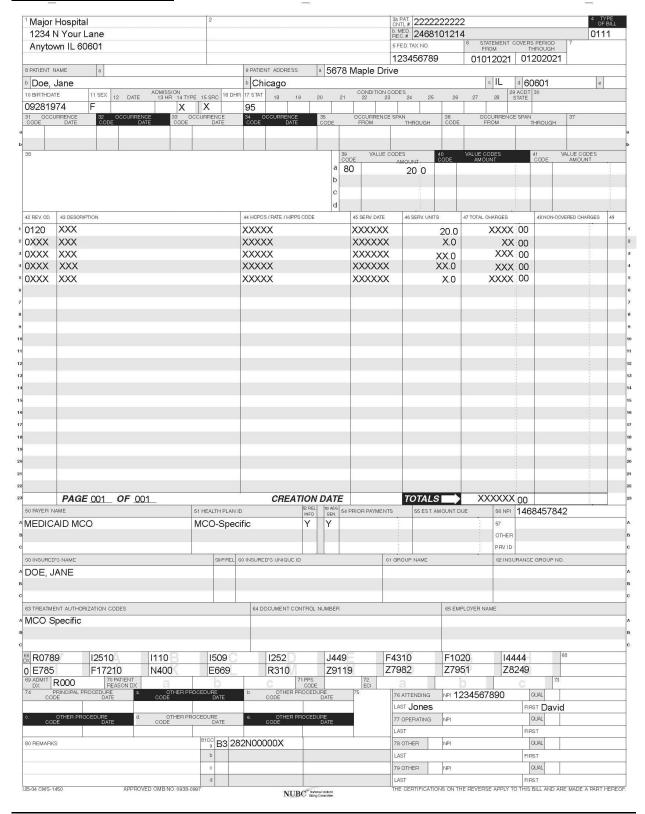
If an individual is receiving hospital long term care services (ADs), as defined at 89 III. Adm. Code 148.50(c), the MCO's liability for the management of such care and payment of claims for covered services begins on the effective date of enrollment.

MCO Coverage Ending During Hospital Long Term Care Stay

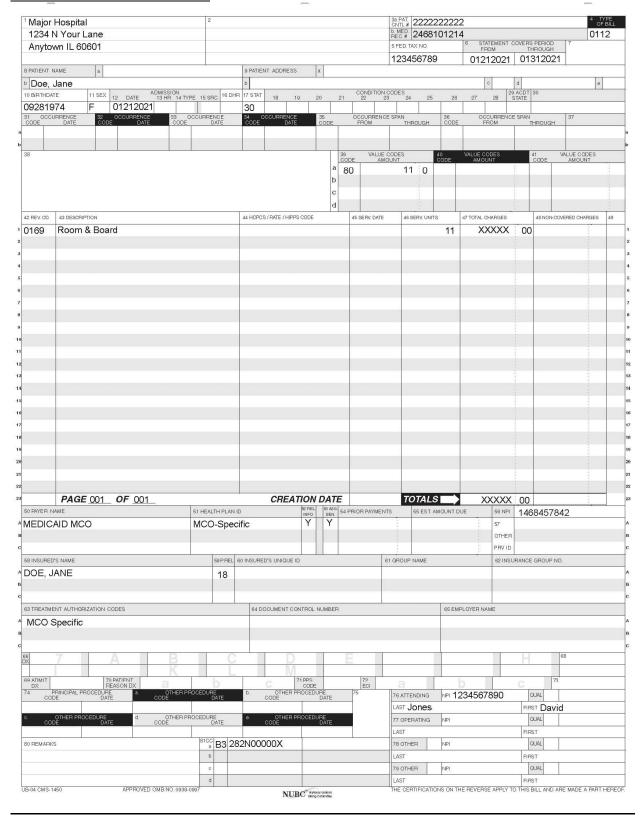
If an individual is receiving hospital long term care services (ADs), as defined at 89 III. Adm. Code 148.50(c), the MCO will be liable for the management of such care and payment of claims for covered services until the effective date of disenrollment.

Administrative Days - Claim Examples:

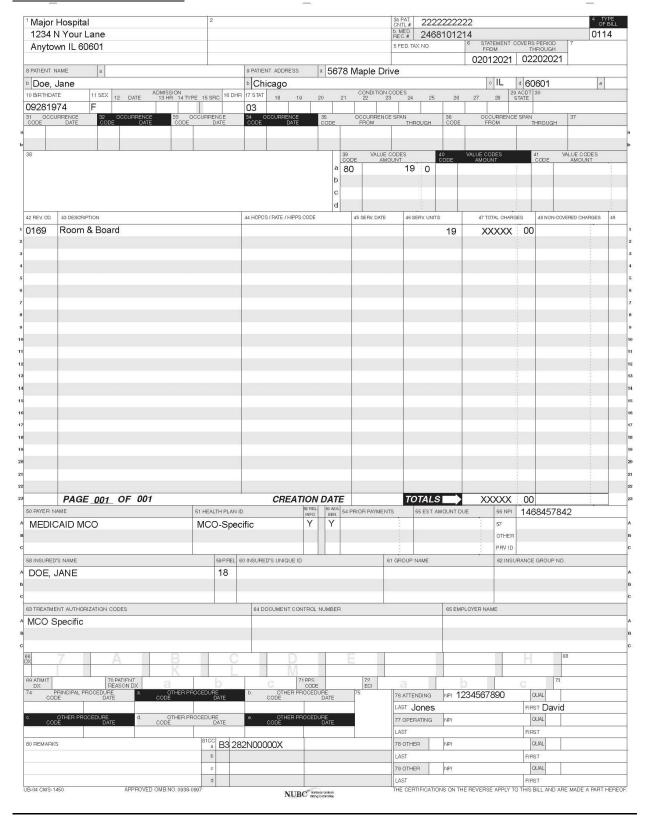
Claim One: Initial IP Stay



Claim Two: Interim First Claim



Claim Three: Interim Final



Appendix J: MCO Potentially Preventable Readmission Policies

MCO	Policy	Status
Meridian (Centene)	MeridianHealth Readmission Policy (06/01/21)	Policy is active.
ABH (CVS/Aetna)	ABH – IL Readmission Policy	Policy is active.
Molina	Molina IL Readmissions Policy (06/10/21)	Revised policy is active.
BCBSIL	BCBSIL Readmissions Policy (06/04/21)	Revised policy is active.
CountyCare	CountyCare Readmission Policy (07/01/21)	Revised policy is active.

Appendix K: MCO Complaint Tracking Process

Under the MCO internal dispute process, MCOs are required to assign providers a tracking number for each complaint submitted. The provider must enter this MCO assigned tracking number in the HFS Provider Resolution Portal when completing a complaint ticket. A complaint can only be submitted to the HFS Provider Resolution Portal after using the MCO internal dispute process.

This memo contains information on how to obtain a MCO tracking number.

Aetna Better Health:

MCO Internal Dispute Process Instructions:

Provider Dispute Form -

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/IL%20Provider%20Dispute%20and%20Resubmission%20Form.pdf

Provider Manual –

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/Aetna%20Better%20Healt h%20of%20Illinois%20Provider%20Manual.pdf

MCO Assigned Tracking Number Examples:

MCO Assigned Tracking Number Instructions:

As of February 27, 2022, there is a new tracking ID that is now live on Aetna's Provider Portal for electronic claim disputes. The tracking ID will always begin with a T (for tracking) followed by mm/dd/yy format and a combination of letters and numbers. Providers will be issued this tracking number upon submission of their electronic claim disputes and can view it in the Portal via the "Claims Search" section by searching and selecting the claims in question.

Prior to this functionality go live, the tracking ID when mailing in or resubmitting a claim dispute/reconsideration through Aetna's Provider Portal is the adjusted claims number from the provider remittance (i.e., the 13-digit

To submit through the portal; follow the directions at this link: https://medicaid.aetna.com/MWP/login.

Aetna MMAI:

MCO Internal Dispute Process Instructions:

Non-Par Appeal Form -

https://www.aetnabetterhealth.com/illinois/assets/pdf/ILMMAINonParAppealForm.pdf

Par Provider Dispute Form -

https://www.aetnabetterhealth.com/illinois/assets/pdf/ILParProviderDisputeForm.pdf

Online Provider Dispute Instructions -

https://www.aetnabetterhealth.com/illinois/assets/pdf/OnlineProviderDisputeInstructions_IL.pdf

MCO Assigned Tracking Number Example:

Non-Par Appeal Format: (AP000000000000)

Par Provider Dispute: Aetna MMAI uses the Claim number for tracking

MCO Assigned Tracking Number Instructions:

No specific instructions are posted for assigned tracking number(s). Provider disputes and appeals are identified by using Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice. This is noted in the footer of Provider Appeals Form.

BlueCross BlueShield:

MCO Internal Dispute Process Instructions:

Instructions -

https://www.bcbsil.com/provider/education/2021/2021 07 21.html

MCO Assigned Tracking Number Examples:

All BCBSIL claim disputes are assigned a 12-digit unique tracking ID number, which will appear in the following format: 193450004656.

MCO Assigned Tracking Number Instructions:

For status updates, call Customer Service at 877-860-2837 and ask for a reference number/12-digit unique tracking ID for your dispute. Allow 7-10 business days before requesting the reference number. For complete instructions, please visit this link: https://www.bcbsil.com/provider/education/2021/2021 07 21.html.

Contact:

Main: Customer Service at 877-860-2837

• Escalation: Provider network govproviders@bcbsil.com

CountyCare:

MCO Internal Dispute Process Instructions:

Provider Dispute Submission User Guide -

https://countycare.com/wp-content/uploads/Provider-Dispute-System-User-Guide V2 Revised-link2.pdf

Dispute Portal -

https://countycareproviderdispute.jira.evolenthealth.com/

MCO Assigned Tracking Number Examples:

Upon submission, a CountyCare tracking number will populate at the top of the dispute ticket. CountyCare tracking numbers lead with 03:

• Format: 03-YYMMDD-xxxxx, Example: 03-191001-

00001 MCO Assigned Tracking Number Instructions:

The provider can go to the dispute portal and view all disputes on their inventory under "requests" in the top right. This is the best way to locate the MCO tracking number.

Contact:

Becca Barrera hfsrequest@cookcountyhhs.org

Humana:

MCO Internal Dispute Process Instructions:

Provider Manual -

http://apps.humana.com/marketing/documents.asp?file=4174586

Complaint Tracking Process Provider Notification – https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=3942328

MCO Assigned Tracking Number Example:

When submitting a complaint/dispute to:

- Humana:
 - o 12-13 character alphanumerical code
- Provider Portal (Availity):
 - o 32-36 character alphanumerical code, depending upon inclusion of the dashes
- Beacon (Humana Behavioral Health):
 - o 15 numeric characters in length, separated by a dash after the eighth digit.

MCO Assigned Tracking Number Instructions:

Humana is required to assign the provider an MCO Tracking Number for each complaint submitted through the Humana internal dispute process. Telephonically submitted disputes may not generate a reference number if the dispute is resolved during the call. However, disputes submitted via mail or fax will always generate a reference number.

Please note, allow two – three business days for a tracking number to be generated for a faxed dispute prior to calling Humana in the event you are unable to locate an MCO Tracking Number, to account for required system generation timelines.

If you do not know or are unable to locate the MCO Tracking Number, providers can call Humana Provider Services at **800-457-4708** between 7 a.m. to 7 p.m. Central time, Monday through Friday. Once the case is located, the Humana Provider Services representative will give you the MCO Tracking Number.

Meridian/Youthcare:

MCO Internal Dispute Process Instructions:

HCI -

Claims with a date of service July 1, 2021 or later https://www.ilmeridian.com/providers/resources/forms-resources/claim-dispute-dos-july-1--2021-and-after.html

Claims with a date of service July 1, 2021 or earlier https://corp.mhplan.com/en/dispute-form/

YouthCare -

<u>Login | YouthCare HealthChoice Illinois (ilyouthcare.com)</u>

MMAI – Login

Provider Notice -

https://www.ilmeridian.com/newsroom/meridianhealth-provider-information-regarding-system-updates-eff.html

MCO Assigned Tracking Number Examples:

Prior to 7/1/2021: 07-210427-52852

YouthCare, MMAI and HCI after 7/1/2021: U327I2W00046

MCO Assigned Tracking Number Instructions:

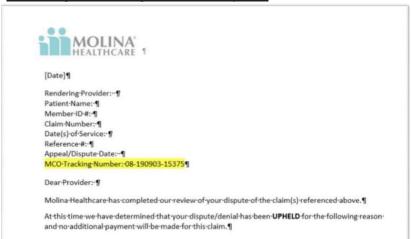
The tracking number can be obtained through the links above. For the process for dates of service, prior to 7/1/2021, the provider will fill out the electronic dispute form. Once complete, they will receive a confirmation PDF with the Tracking Number listed at the top. For YouthCare, MMAI and the HCI process for dates of service after 7/1/2021, the provider will log into the Provider Portal and will complete the claim dispute. Once finished, the provider will receive the tracking number.

Molina:

MCO Internal Dispute Process Instructions:

Complaint Tracking Memo – HFS-Complaint-Tracking-Provider-Memo clean-FNL.pdf

MCO Assigned Tracking Number Examples:



MCO Assigned Tracking Number Instructions:

Providers can obtain their MCO tracking number on the dispute determination letter, or they can call Molina Providers Services at 855-866-5462.