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Blue Cross Community Health Plans

CountyCare
A MEDICAID HEALTH PLAN

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MOLINA HEALTHCARE



IAMHP
ILLINOIS ASSOCIATION OF MEDICAID HEALTH PLANS

Comprehensive Billing Manual

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VERSION 35.0

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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
35.0	9/4/2025	**PART A.III: General Claim Submission Guidelines** **D. Type of Claim Submission**	• Updated links and addresses for Aetna Better Health and Blue Cross Community Health Plan
35.0	9/4/2025	**PART A.IV Claim Disposition** **B.iv Corrected Claims**	• Updated links and addresses for Aetna Better Health and Blue Cross Community Health Plan
35.0	9/4/2025	**PART C.IX: HCBS Waiver Providers** **C. Claim Submission Requirements**	• Updated Coding Requirements table/code changes
35.0	9/4/2025	**Appendix F**	• Updated instructions to Form 1977 (see Note under Part IV instructions)
35.0	9/4/2025	**PART C.IV: Professional Services** **D.iii: Allowable Practitioner Claims**	• Language added under 340B section regarding hospital outpatient claims that include drugs
35.0	9/4/2025	**PART C.VII: SUPR Providers** **C.ii Professional Services**	• Clarification added regarding Rendering Providers • Telehealth guidance added
35.0	9/4/2025	**PART B.VIII: SMHRF Providers** **F. Coding Requirements**	• Language added regarding billing of LOA days
35.0	9/4/2025	**PART C.XVIII: Genetic Counsellors**	• COS changed from 100 to 144
35.0	9/4/2025	**PART C.I: FQHC, RHC and ERC Providers** **E.iv Submission Guidelines**	• Added Meridian to list of plans requiring inclusion of Rendering Provider NPI on claim
35.0	9/4/2025	**PART C.VII: SUPR Providers** **NEW SECTION ADDED**	• Guidance regarding billing for SBIRT services
35.0	9/4/2025	**PART C.V: Pharmacy Providers** **D.viii HIV/Contraceptive Services**	• Link added for HIV services Standing Order
35.0	9/4/2025	**PART C.VI. Community Behavioral Services** **D. Pathways to Success**	• Clarified CCSO monthly billing span (26 days) • Removed reference to OBRA codes vis a vis member authorization
34.0	4/11/25	**PART C.VI: Community Based Behavioral Services** **C. Coding and Billing Guidelines**	• Moved IATP: LPHA Review from Group A service to Group B service
34.0	4/11/25	**Appendix M: HBIA/HBIS Populations**	• Added note regarding termination of HBIA Program
34.0	4/11/25	**Part C.V: Pharmacy Providers**	• Guidance added regarding HIV and Hormonal Contraceptive Assessment and Consultation Services
34.0	4/11/25	**New Section Added**	• Doulas and Lactation Consultants
34.0	4/11/25	**New Section Added**	• Certified Community Behavioral Health Clinics
34.0	4/11/25	**PART C.IV Professional Services** **I. Family Planning, Pregnancy/Maternity Care Services**	• Clarification added re billing for multiple births • Corrected prenatal billing guidance for subsequent visits
34.0	4/11/25	**APPENDIX L: COB/TPL**	• Clarification added re billing for multiple births
34.0	4/11/25	**PART C.XVIII: Genetic Counseling Services** **B.i IMPACT Registration**	• Added Legacy PT and COS to Enrollment Table
34.0	4/11/25	**APPENDIX G: ORP** **B. Provider types billing 837P**	• Correction to requirements for Optometrists and Podiatrists providing services in LTC settings (POS 31,32,33)and

Version	Date	Section Modification	Description
34.0	4/11/25	**PART C.III: Pediatric Services** **C. Coding Requirements**	• Removed note that BCBS does not allow billing for well and sick child visit on the same day (i.e., BCBS DOES allow this)
34.0	4/11/25	**PART C.XV: Diabetes Prevention Program (DPP) and Diabetes Self-Management and Education (DSMES) Services**	• Addition of POS 10 and modifier 93 for telehealth services
34.0	4/11/25	**PART C.XVIII: Genetic Counseling Services** **C. Coding Guidance** **i. Allowable Billing Codes**	• Replacement of Procedure Code 96040 with 96041
33.0	11/7/24	**PART C.XV: Diabetes Prevention Program (DPP) and Diabetes Self-Management and Education (DSMES) Services**	• Changes to upper age limit for services effective Nov 1, 2024
33.0	11/7/24	**New Section Added**	• Genetic Counseling Services
33.0	11/7/24	**PART C.XII: Transportation Services** **D. Billable Services** **x Transportation Vendors**	• Changed CountyCare Transportation Vendor to Modivcare (effective 8/1/24)
33.0	11/7/24	**PART C.I: FQHCs, RHCs and ERCs** **PART C.VI: Community Behavioral Services**	• POS 27 – Outreach Site/Street added as allowable POS
33.0	11/7/24	**PART C.III: Pediatric Services** **C. Coding Guidance**	• Addition of H1000 for Perinatal Depression Screening
33.0	11/7/24	**Appendix I – Administrative Days**	• Clarification on when to include Day of Discharge in Value Code 80 calculation
33.0	11/7/24	**PART B.IX: ASTCs** **C. IMPACT Enrollment Requirements**	• Added required taxonomy code
33.0	11/7/24	**New Section Added**	• Acupuncture Services
33.0	11/7/24	**PART B.II: Outpatient Hospital** **C. Coding Guidance** **ii. EAPG Changes DOS after 7/1/2020**	• Added Critical Access Hospital Taxonomy for Therapy Services billing with COS 24
33.0	11/7/24	**PART B.VIII: Specialized Mental Health Rehabilitation Facilities** **F. Coding Requirements**	• Clarified the use of Rev Code 0130 for 3 and 4 bed rooms
33.0	11/7/24	**Part B.XII: Home Health Care and** **Part C.VIII: HCBS Waiver Providers**	• Clarified PT 057 cannot bill services to MCOs
33.0	11/7/24	**PART C.VI: Community Behavioral Services** **E. Psychiatric Collaborative Care Model (COCM) Services**	• Addition of new section on billing for CoCM services
33.0	11/7/24	**PART C.XV: DPP/DSMES Services** **B. Provider Type** **i. IMPACT Registration**	• IMPACT enrollment grid added
33.0	11/7/24	**PART C.XII: Transportation Services**	• Addition of Network Transportation Companies as a new Provider Type for NEMT services
33.0	11/7/24	**Appendix L – COB/TPL**	• Updates to Plan Specific Guidance when TPL is terminated
33.0	11/7/24	**PART A.IV: Claim Disposition** **B. Provider Type** **vi. Overpayments/Recoupments**	• Additional exception to the 12 month time limit added
32.0	6/4/24	**New Appendix Added**	• Appendix M: HBIA/HBIS Populations
32.0	6/4/24	**PART B.XI: Hospice** **H. Key Data Fields Requirements**	• Changed Admitting Diagnosis Field from Required to Conditional

Version	Date	Section Modification	Description
32.0	6/4/24	**PART C.VII: SUPR Providers C. Coding Guidance iii. Institutional Claims**	• Clarified that claim can cross months for stays under 30 days (Bill Type XX1)
32.0	6/4/24	**PART C.VIII: HCBS Waiver Providers C. General Claim Submission Requirements**	• Addition of the TG modifier for Personal Emergency Response Systems with Fall Detection
32.0	6/4/24	**Appendix L – COB/TPL**	• Updates to Plan Specific Guidance when TPL is terminated
31.0	4/1/24	**PART C.IV - Professional Services Family Planning, Pregnancy/Maternity Care and Reproductive Health Care**	• Updated to include billing for 2 postpartum visits
31.0	4/1/24	**Appendix I: Administrative Days**	• Updated language on Admit Dates for claims
31.0	4/1/24	**PART B.I - Inpatient Hospital C. Coding Guidance iii Revenue Codes**	• Updated guidance regarding billing non-covered revenue codes effective 4/1/24
31.0	4/1/24	**PART B.I - Inpatient Hospital C. Coding Guidance v. Interim Claims**	• Clarified language on calendar month timeframes for interim claiming
31.0	4/1/24	**PART C.VII – SUPR Services C. Coding Requirements**	• Updated inpatient and outpatient coding tables
30.0	1/22/24	**Meridian and Molina Updates**	• Updates to links/contacts/addresses for Meridian and Molina health plans
30.0	1/22/24	**PART C.I FQHCs, RHCs, and ERCs**	• Updates to Provider Registration and claim form elements • Updated guidance re maternity billing
30.0	1/22/24	**PART B.I - Inpatient Services B. Provider Type AND v. Interim Claims**	• Updated guidance and additional examples added
30.0	1/22/24	**PART C.IV - Professional Services I. Family Planning, Pregnancy/Maternity Care and Reproductive Health Care**	• Updated guidance effective 10/1/22 regarding global maternity billing
30.0	1/22/24	**Appendix L – COB/TPL**	• Updated guidance regarding Maternity Billing • Addition of Plan Specific Guidance when TPL coverage is terminated
29.0	10/27/23	**PART B.I - Inpatient Services B. Provider Type**	• Added guidance on billing for different Categories of Service
28.0	8/8/23	**PART C.IV - Professional Services M. Psychiatry**	• Updated to include information regarding services rendered by Licensed Clinical Professional Counselors (LCPCs) and Licensed Marriage and Family Therapists (LMFTs)
28.0	8/8/23	**PART C.X – Dental Providers**	• Update to Meridian Dental Vendor to Envolve
28.0	8/8/23	**New Appendix Added**	• Appendix L: Third Party Liability and Coordination of Benefits added
28.0	8/8/23	**PART C.V - Pharmacy Providers D. Billable Services i. Retail Point of Sale (POS) Pharmacy Providers**	• Updated new CountyCare PBM information effective 7/1/2023
28.0	8/8/23	**PART C.VIII - Home and Community-Based (HCBS) Waiver Providers C. General Claim Submission Requirements**	• Update ABH-IL specific guidance when billing T2003 (Adult Day Services transportation)

Version	Date	Section Modification	Description
28.0	8/8/23	**PART C.VI - Community Behavioral Services** **C. Coding and Billing Guidelines**	• Updated CBS Services tables with new depression screening codes effective with dates of service beginning 4/1/2023
28.0	8/8/23	**PART C.III - Pediatric Services** **C. Coding Requirements**	• Updated coding tables with new depression screening codes effective with dates of service beginning 4/1/2023
27.0	1/5/23	**PART A.IV - Claim Disposition**	• Updates to links and addresses for Meridian for EOP access, corrected claim and dispute submissions
27.0	1/5/23	**PART B.VI - Long Term Care/Skilled Nursing Facilities** **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	**PART C.VI - 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 (PART C.XV)
27.0	1/5/23	**PART C.VI - Community Behavioral Services** **C. Coding Guidelines**	• 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	**PART C.I - FQHCs, RHCs, and Encounter Rate Clinics** **E. 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	**PART C.VI - Community Behavioral Services** **C. Coding Guidelines**	• Correction to POS 10 to be an on-site POS
26.0	10/26/22	**PART C.XI – Vision Providers** **D. Billing Requirements** **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	**PART C.I - FQHCs, RHCs and Encounter Rate Clinics** **E. 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	**PART C.VI - Community Behavioral Services** **C. Coding Guidelines**	• 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	**PART B.VIII - Specialized Mental Health Rehabilitation Facilities** **F. Coding Requirements**	• Note added regarding using appropriate revenue code for add-on payments.
25.0	7/20/22	**PART B.I - 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	**PART C.IV – Professional Services** **G. Anesthesia**	• Guidance added regarding billing for office-based pain management services.

Version	Date	Section Modification	Description
25.0	7/20/22	**PART B.I - Inpatient Hospital C. Coding Guidance iv. Covered and Non-Covered Days**	• Clarification added for Aetna Better Health of Illinois
25.0	7/20/22	**PART C.XII - 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	**PART A.IV - Claim Disposition B. Provider Type vi. Overpayments/Recoupments**	Updated timeframe for recoupment from 18 to 12 months
24.0	5/2/22	**PART C.V - Pharmacy Providers D. Retail Point-of-Sale (POS) Pharmacy Services**	Meridian PBM Vendor change to CVS Caremark
24.0	5/2/22	**PART B.II - 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	**PART C.VII - SUPR Services C. Coding Requirements iv. Interim Claims**	Clarification added regarding Interim Claims and billing for stays exceeding 30 days.
24.0	5/2/22	**PART C.VI - 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	**PART B.VII - Supportive Living Facilities F. Billing Requirements**	Clarifying language added regarding Leave of Absence billing requirements
24.0	5/2/22	**PART B.1 - Inpatient Hospital C. Coding Guidance ii. 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	**PART C.VIII - HCBS Waiver Providers C. Claim Submission Requirements**	Corrected information for Box 33B inputs

Version	Date	Section Modification	Description
23.0	9/13/21	**PART C.II - School-based/Linked Health Centers** **E. Covered Services**	Added required modifiers for behavioral health service billing
23.0	9/13/21	**PART C.V - Pharmacy** **D. Billable Services** **vi. Drug Wastage**	Added language regarding 340B Purchased Drugs
22.0	4/16/2021	**PART C.V - Pharmacy Providers** **D. Billable Services**	Addition of Plan Bin/PCN GroupID information
22.0	4/16/2021	**Aetna Better Health updates**	Revised billing guide to update all IlliniCare information/links to Aetna Better Health information
22.0	4/16/2021	**New Sections Added**	• School-based Health Centers • Birthing Centers • Specialized Mental Health Rehabilitation Facilities (SMHRFs)
22.0	4/16/2021	**New Appendix Added**	Billing guidance on Administrative Days added as Appendix I
22.0	4/16/2021	**PART C.XII – Transportation Services**	• 4/1 transition of emergency transportation claims to FFS billing to HFS • MLTSS secondary payment guidance
22.0	4/16/2021	**PART B.VI – Long Term Care/Skilled Nursing Facilities** **C. Billing Requirements**	Clarification on MLTSS billing for Medicare-covered services
21.0	1/13/2021	**PART A.IV - Claim Disposition** **B. Provider Type** **vi. Overpayments/Recoupments**	Clarification of BCBSIL policy
21.0	1/13/2021	**PART C.VII - SUPR (Substance Use Prevention and Recovery)** **C. Code Requirements** **iv. Interim Claims**	Removed 30-day increment and changed to 'monthly increments'
21.0	1/13/2021	**PART C.XII - Transportation Services** **D. Billable Services** **vii. Physician Certification Statement (PCS)** **x. Transportation Vendors**	Change in Molina Healthcare Transportation Vendor with updated contact information/instructions
21.0	1/13/2021	**PART B.I - Inpatient Hospital**	Added guidance on billing for Long-Acting Reversible Contraceptives (LARCs) in the inpatient setting
21.0	1/13/2021	**PART C.XIV - Custom Orthotic, Prosthetic and Pedorthic Services**	Added updated information on billing for quantity limits and billing for pairs
21.0	1/13/2021	**PART C.I - Federally Qualified Health Clinics, Rural Health Centers and Encounter Clinics**	Changes to allowable POS Changes to Aetna Better Health (IlliniCare claim instructions
21.0	1/13/2021	**New Sections Added**	• Vision Services • Pharmacy Services
20.0	9/4/2020	**PART C.VII - SUPR (Substance Use Prevention and Recovery) Services** **C. Coding and Billing Guidelines**	Added item 'a' under number 8, regarding Value Code 80 for SUPR providers.

Version	Date	Section Modification	Description
20.0	9/4/2020	**PART B.I - Inpatient Hospital (General Acute Care and Children's Hospital)** **C. Coding Guidance** **iv. Covered and Non-Covered Days**	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	**PART C.XII - Transportation Services** **D. Billable Services** **ix. Specific Claim Requirements**	Added updated language regarding reporting mileage to D. vii – Specific Claim Requirements
19.0	8/5/2020	**New Sections added**	• Home and Community Based Health (HCBS) Waiver Providers • Home Health Care (HHC)
19.0	8/5/2020	**PART B.II - Outpatient Hospital**	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)**	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	**PART C.VII - SUPR (Substance Use Prevention and Recovery) Services** **C. Coding Requirements**	Added clarity that MAT services is a weekly event.
18.0	7/23/2020	**Appendix Section added**	Added Sample MCO Recoupment Letters
18.0	7/23/2020	**New Section added**	Added vi. Overpayment/Recoupment to IV. Claim Disposition
17.0	7/8/2020	**PART B.II - Outpatient Hospital** **G. Hospital Billing Scenarios**	Added Scenario 2B for IlliniCare specifications
16.0	4/29/2020	**PART A.IV. Claim Disposition** **B. Provider Type** **v. Claim Dispute**	Updated the Process Requirements by MCO chart
15.0	4/22/2020	**New Section added**	SUPR (Substance Use Prevention and Recovery)
15.0	4/22/2020	**PART B.I - Inpatient Hospital (General Acute Care and Children's Hospital)** **C. Coding Guidance** **ii. Value Codes**	Removed Molina from the Value Code 81 Added Molina to the MCO condition codes
14.0	3/31/2020	**New Sections added**	• Dental • Psychiatric Free-Standing Hospitals • Rehabilitation Hospitals • Long Term Acute Care Hospitals (LTAC)
14.0	3/31/2020	**PART C.VI - Community-Based Behavioral Services** **C. Coding and Billing Guidelines**	Updates/corrections to Billing Scenarios

Version	Date	Section Modification	Description
14.0	3/31/2020	**PART A.IV - Claim Disposition** **V. Claim Dispute**	Blue Cross Blue Shield: Process Requirements by MCO update. Dispute submission by portal is not available.
14.0	3/31/2020	**PART B.II - Outpatient Hospital** **D. Non-APL billing**	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**	Transportation Services
13.0	1/7/2020	**PART B.XI - Hospice** **F. Patient Credit File** **PART B.VI - Long term Care/Skilled Nursing Facility** **E. Patient Credit File** **PART B.VII - Supportive Living Facility** **E. Patient Credit File**	HFS Policy Change effective 12/1/2019 - MCO's no longer required to accept MEDI Screenshots.
13.0	1/7/2020	**PART B.I - Inpatient Hospital** **D. Other** **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.
12.0	12/9/2019	**PART B.XI - Hospice** **G. Value Codes**	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**	Appendix G: Ordering, Referring, Prescribing (ORP)-National Provider Identifier (NPI) Requirements
10.0	10/10/2019	**Appendix Section added**	Appendix F: Hysterectomy (HFS 1977) and Sterilization (HFS 2189) Memo and Forms
10.0	10/10/2019	**New Section added**	CBS (Community Based Behavioral Services)
9.0	9/30/2019	**New Section added**	Pediatric Services
9.0	9/30/2019	**New Section added**	Federally Qualified Health Centers, Rural Health Centers and Encounter Rate Clinics
8.0	9/18/2019	**PART A.IV - Claim Disposition** **iv. Corrected/Replacement Claims**	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**	Hospice
7.0	9/3/2019	**PART B.I - Inpatient Hospital** **C. Coding Guidance** **v. Interim Claims**	Interim claims should be billed in one-month increments
6.0	7/8/2019	**New Section added**	Long-term Care/ Skilled Nursing Facility
5.0	6/20/2019	**New Section added**	Claim Disposition
4.0	5/29/2019	**New Section added**	Supportive Living Facility (SLF)

Version	Date	Section Modification	Description
3.0	5/14/2019	**New Section added**	Custom Orthotic, Prosthetic and Pedorthic Services
2.0	3/27/2019	**New Section added**	Inpatient Hospital (General Acute Care and Children's Hospital)
1.0	2/19/2019	**Initial IAMHP Manual created**	Overview Claims section and Outpatient Hospitals

Part A: General Claims Information

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.
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.**
Molina Healthcare	To find your Molina Provider Relations Manager click here 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 an MCO, the specialties and sub-specialties registered in HFS Provider IMPACT system are critical to accurate claims payment. If the appropriate specialty or sub-specialties 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.

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.

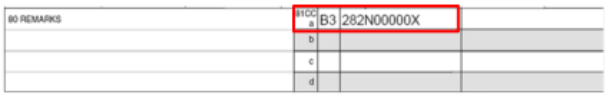
The taxonomy code used must match a corresponding Category of Service (COS), Procedure Code (PC) and/or Place of Service (POS). A crosswalk of taxonomies with COS, PC and POS is available here.

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

UB-04

PAPER SUBMISSION:

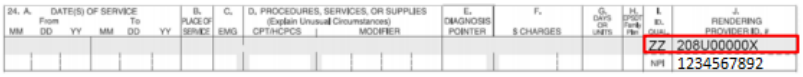
Billing – Box 81CCa should contain the qualifier of "B3" in the left column and the taxonomy code in the middle column.



CMS 1500

PAPER SUBMISSION:

Rendering – Box 24i should contain the qualifier "ZZ." Box 24j (shaded area) should contain the taxonomy code.



Billing – Box 33b should contain the qualifier "ZZ" along with the taxonomy code.



Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of "ZZ" along with the taxonomy code in the next column.



IMPORTANT NOTES:

- 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 Correct Coding Initiative (NCCI) guidelines **unless otherwise specified by HFS**. Ensure that all appropriate modifiers are included on submitted claims.

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.

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

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:
    - is true, accurate, prepared with knowledge and consent of provider,
    - 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.

MCO	Clearinghouse	Payor ID	Resources/Notes
Aetna Better Health® of Illinois	Multiple Click here for listing	68024	Contact info for the clearinghouses can be found here.
Blue Cross Community Health Plan (BCCHP)	Availity	MCDIL **Eff. with DOS beginning 8/1/25:** 66012	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	MHPIL*	Contact info for the clearinghouses can be found here. *Providers utilizing Change Healthcare as their clearinghouse must submit use Payor ID MCCIL.
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 report**[2] back to

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

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**[3] 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. *Providers 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.

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

1. Select clearinghouse to utilize
2. Contact the clearinghouse to inform them you wish to submit electronic claims to which MCOs.
3. Inquire with the clearinghouse what data records are required.
4. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to the MCO, and also those claims not meeting the clearinghouse requirements. The second report will be a claims status report showing claims submitted to, but rejected by, the MCO. These claims need to be corrected and resubmitted. ALWAYS review the acceptance and claims status reports for any rejected claims.
5. MOST importantly, all claims must be submitted with providers' identifying numbers. See the CMS 1500 and UB-04 claim form instructions in the Appendix.

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

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

- 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.[4] 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.

[4] 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.

- 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 982970 El Paso, TX 79998-9270
Blue Cross Community Health Plan (BCCHP)	Blue Cross Community Health Plans c/o Provider Services P.O. Box 3418 Scranton, PA 18505 **Eff .with DOS beginning 8/1/25:** Blue Cross and Blue Shield of Illinois P.O. Box 650712 Dallas, TX 75265-0712
County Care Health Plan	County Care Health Plan P.O. Box 211592 Eagan, MN 55121-2892
Meridian	Meridian PO Box 4020 Farmington, MO 63640-4402
Molina Healthcare	Molina Healthcare of Illinois PO Box 540 Long Beach, CA 90806

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://hi.aetnabetterhealth.com/illinois-medicaid/providers/portal.html)
Blue Cross Community Health Plan (BCCHP)	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	Click here (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 to access the Secure Provider Portal
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 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 through the Availity (https://www.availity.com/) provider portal. An enrollment guide can be found here (https://www.bcbsil.com/docs/provider/il/claims/ec/eft-era-tip-sheet.pdf). For more information click here (https://www.bcbsil.com/provider/claims/claims-eligibility/claim-payment)
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	Enroll online at payspanhealth.com or by contacting Payformance Corporation at 877-331-7154.
Molina Healthcare	Molina partners with Change Healthcare/ECHO for electronic payments and remittance advices. Change Healthcare/ECHO registration instructions (link) Questions can be directed to Change Healthcare/ECHO Provider Services at: wco.provider.registration@changehealthcare.com or By phone at: 800-895-0621

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.

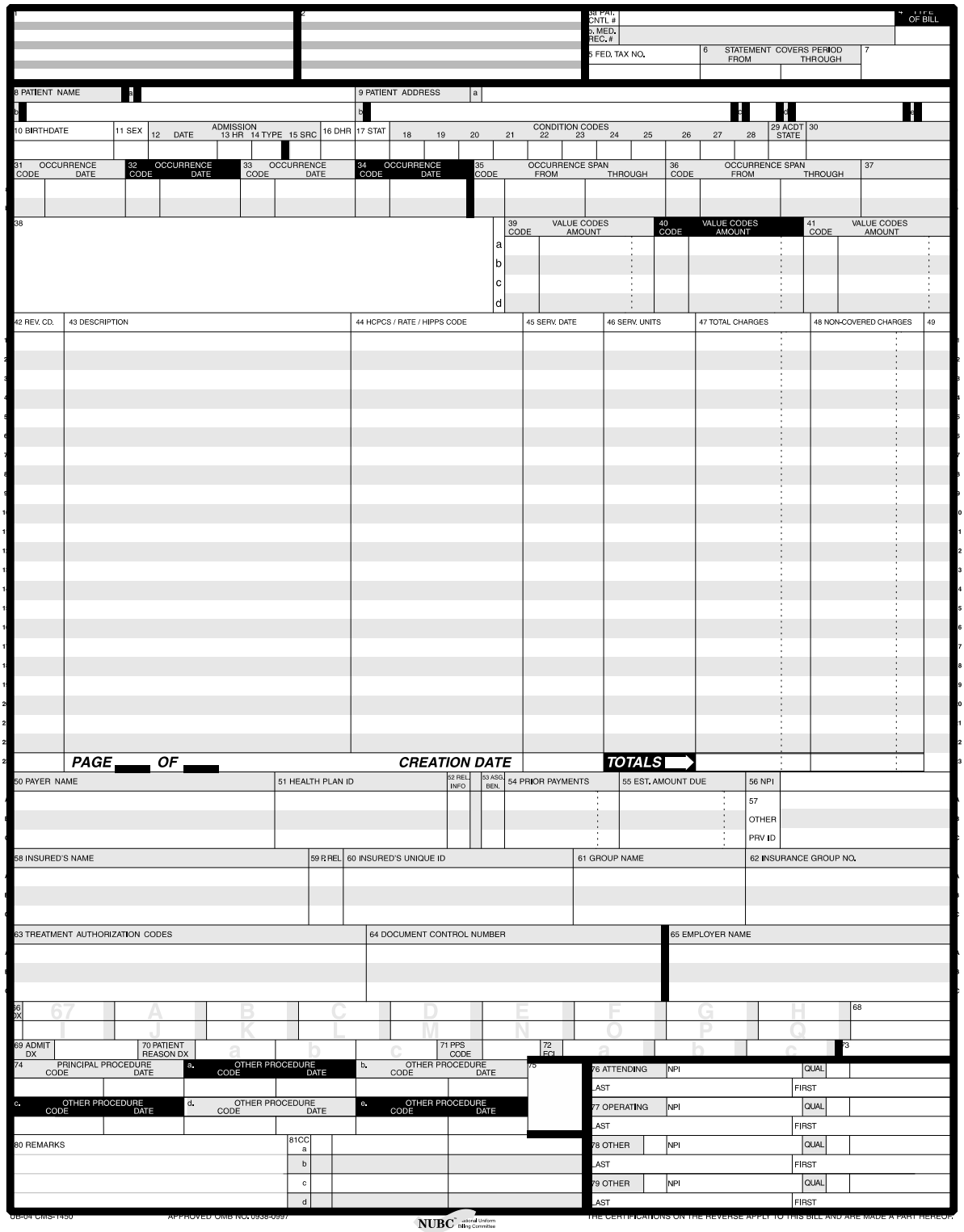
The table below indicates by MCO prior authorization information for inpatient, outpatient and behavioral health services.

MCO	Is an Authorization Required?	How to submit an Authorization?
Aetna Better Health® of Illinois	Prior Auth Tool: (link)	Provider Portal: https://medicaid.aetna.com/MWP/login.fcc Fax: 877-779-5234 Authorization Form: (link) Phone: 866-329-4701
Blue Cross Community Health Plan (BCCHP)	Prior Authorization information can be found here	Phone: 877-860-2837 Physical Health Fax: 312-233-4060 Behavioral Health Fax: 312-233-4099 Medicaid Preauthorization Form: Physical Health (link) Behavioral Health (link) **For outpatient services only, please see Behavioral Health authorization forms** Provider Portal (link) Portal Enrollment (link)
County Care Health Plan	CPT Code List: (link)	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 Summary List: (link)	Provider Portal: (link) Phone: 866-606-3700
Molina Healthcare	Code List by Quarter/Year: (link)	Provider Portal: (link) 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. 2001 Butterfield Rd., Suite 750 Downers Grove, IL 60515

F. Sample Claim Forms

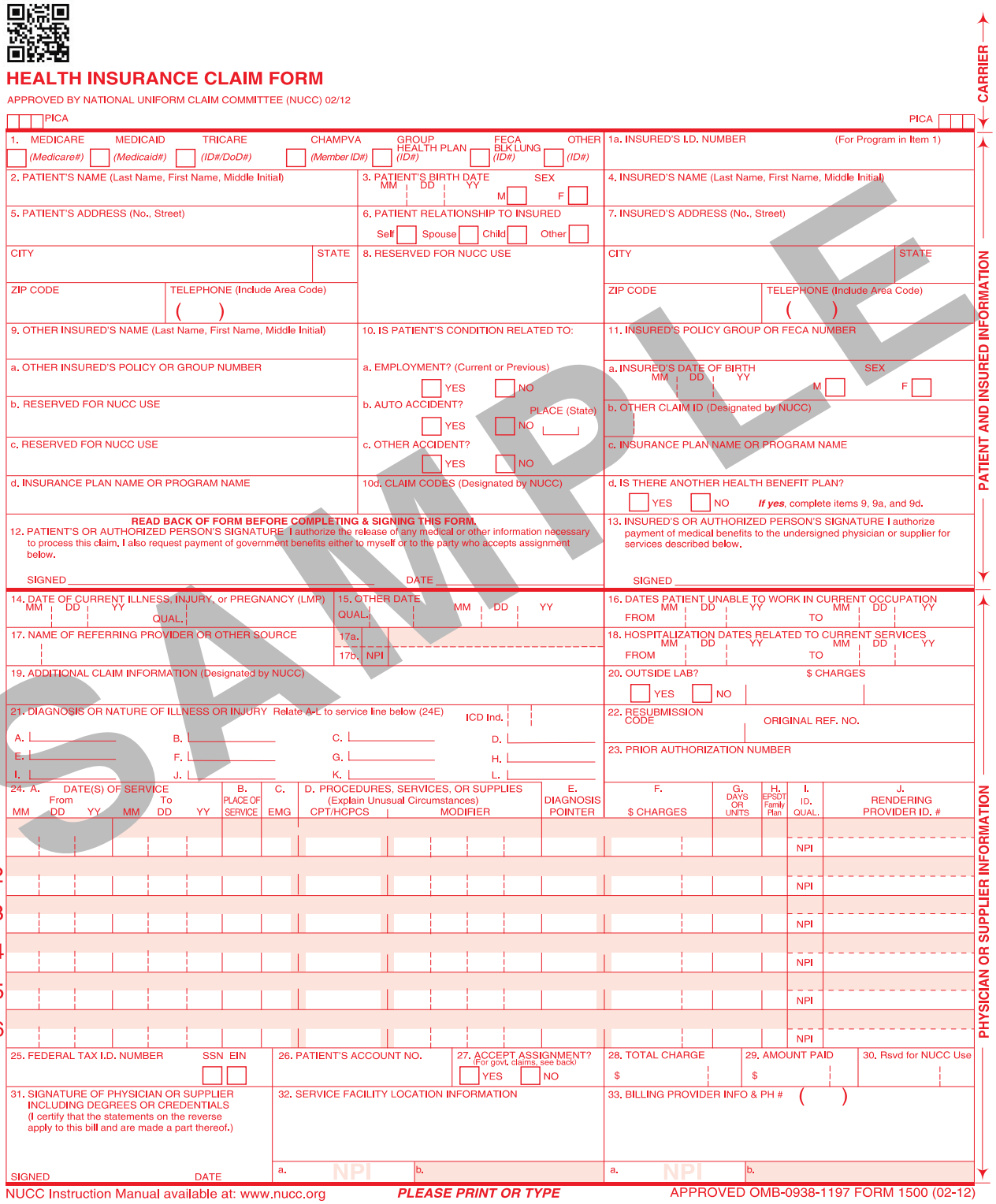
i. UB-04

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.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL 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. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

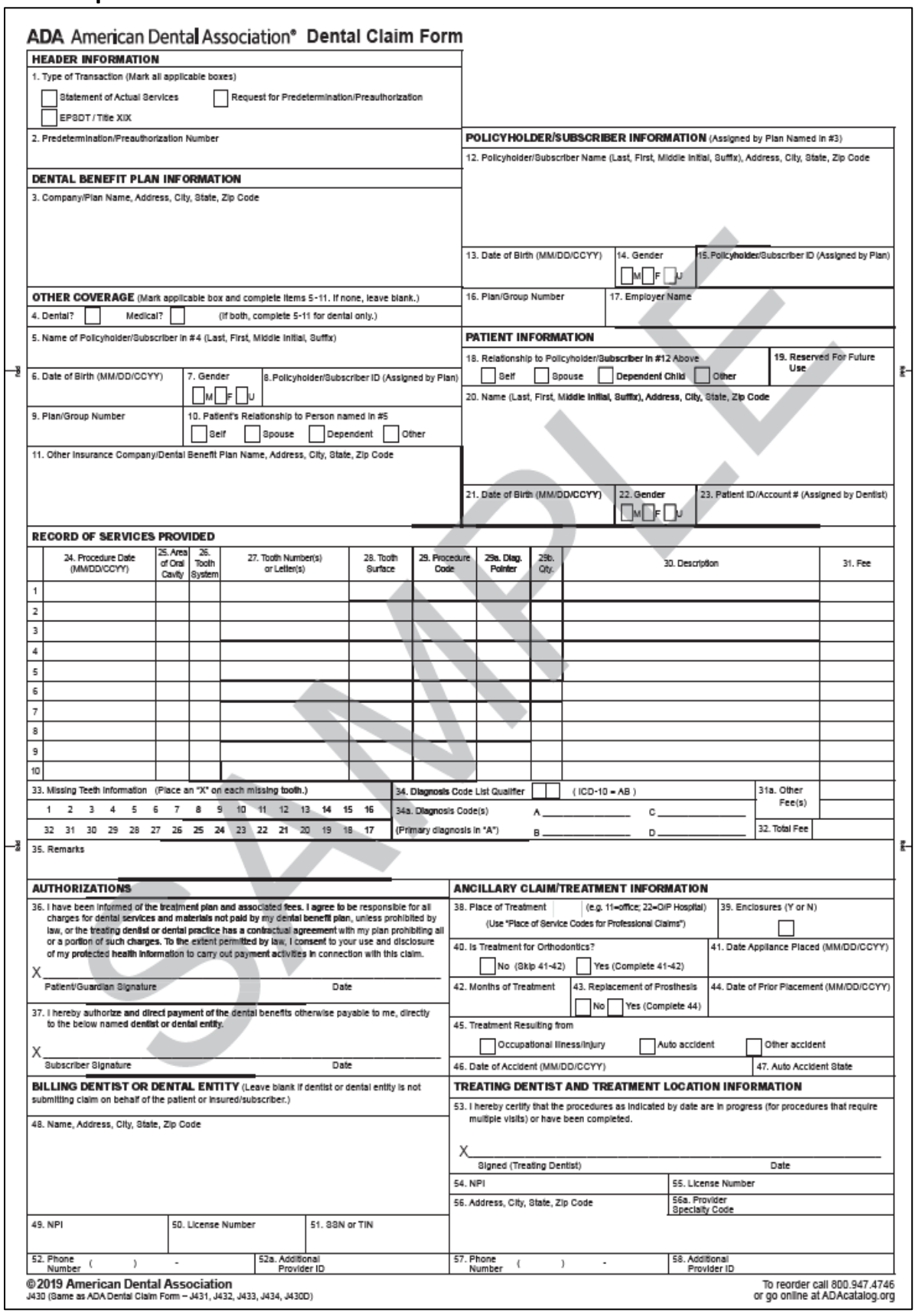
NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

iii. Sample ADA Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 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 or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

SAMPLE

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

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

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

It is very important to review this **claims status report**[6] 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 **your** clearinghouse to ensure the accurate data was sent to the MCO
- If you believe the rejection from the clearinghouse was in error, please contact the MCO directly using the provider escalation process.

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

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.

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**.

MCO	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 signing into Availity Essentials and viewing the User Guide. Click here.
County Care Health Plan	Provider remittance advice/report can be retrieved via CountyCare Provider Portal: https://countycare.valence.care/ or via InstaMed: 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 Zelis (formerly 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 provider portal here.
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/ECHO. Customer Service phone: 800-895-0621 Email: edi@echohealthinc.com Website: http://www.providerpayments.com 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.*

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 4th or 5th 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 submitting 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.**

MCO	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** **P.O. Box 982970** **El Paso, TX 79998-2970**
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 **Eff .with DOS beginning 8/1/25:** **Blue Cross Blue Shield of Illinois** **c/o Provider Services** PO Box 650712 Dallas, TX 75265-0712
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** **P.O. Box 211592** **Eagan, Minnesota 55121-2892**
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 Farmington, MO 63640-4402 INDICATE Claims Correction 3. Meridian's Online Provider Portal: Click here.
Molina Healthcare	Corrected/replacement claims can be submitted via: 1. Molina Healthcare's Availity Essentials Portal (Click here) ***– preferred method*** 2. EDI - see process/guidelines noted below 3. Paper – Please submit to: **Molina Healthcare of Illinois, Inc.** **P.O. Box 540** **Long Beach CA 90806** **Availity Portal Instructions:**

MCO	Corrected Claim Submission Methods by MCO
	• 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: 1. "7" – REPLACEMENT (replacement of prior claim) 2. "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

MCO	Claim Dispute Process
Aetna Better Health® of Illinois	A claim dispute is to be used **only** when a provider has received an unsatisfactory response to a request for reconsideration. (Click here for instructions and a reconsideration form). 1. **Submit via Provider Portal:** Not available 2. **Submit via Customer Service Line:** Not available 3. **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

MCO	Claim Dispute Process
Blue Cross Community Health Plan (BCCHP)	**To submit claims inquiries, disputes and service authorization disputes for BCCHP:** Continue to call 877-860-2837 to submit a provider claim inquiry or dispute by phone. Updated inquiry or dispute forms are available on the website. 1. **Submit via Provider Portal:** Not available 2. **Submit via Mail:** Blue Cross Community Health Plans C/O Provider Services PO Box 650712 Dallas, TX 75265-0712 3. **Submit via Fax:** Fax completed forms and supporting documentation to 855-590-5690.
County Care Health Plan	1. **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** 4. **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.
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 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 63640-4402** 4. Submit via Provider Relations Representatives: Not Available
Molina HealthCare	1. Submit via Availity Portal: Not Available 2. Submit via Fax: 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 • 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.

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[7, 8] 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;
- the provider has already been paid in full by any other payer, third party, or workers' compensation insurer; or
- an insurer contracted with HFS is required by HFS to recoup or offset payments due to a federal Medicaid requirement.

[7] 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.
[8] 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.

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.

MCO	Provider Portal Access
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 Availity website, 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)

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
Online Claims Submission	Yes	No	No	Yes	Yes
Submit Corrected/Replacement Claims	Yes	No	No	Yes	Yes
Claims Status Details:					
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.*

Part B: Institutional Billing (837I or UB-04 claim types)

I. 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.

i. 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.

ii. 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.

iii. 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)
- 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
    - 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 principal 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**.

iv. 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)
- 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 **not registered** for one of the following Category of Services, then the provider **may not submit a claim** 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 principal 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**.

v. 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 principal 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

vi. General Acute Care and Children's Claim 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)	18 and over
					282NC2000X (General Acute Care Hospital - Children) 281PC2000X (Chronic Disease Hospital - Children)	Under 18
Beneficiaries under the age of 18	Psych	Inpatient COS = 021 Outpatient COS = 027,028	Children's and General Acute	** Children's 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	Children's 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

Age Restrictions	Services	APR DRG/COS	Hospital Type	Billing NPI/ Medicaid ID	Taxonomies	Taxonomy by Age
Beneficiaries under the age of 18	Rehab	Inpatient COS = 022 Outpatient COS = 029	Children's and General Acute	** Children's Hospital NPI/ID	283XC2000X (Rehabilitation Hospital – Children)	Under 18
Beneficiaries 18 years old and over	Rehab	Inpatient COS = 022 Outpatient COS = 029	Children's 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)	18 and over
					283XC2000X (Rehabilitation Hospital – Children)	Under 18

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

vii. General Acute Care Hospital Billing for Different Categories of Service

Inpatient Facility Claims for Hospitals Registered as HFS Provider Type 30 – General Acute Care Hospital

- The discharge date for the HFS category of service being provided dictates the base rate in the grouper software for APR DRG assignment.
- For HFS' grouper (Optum's Web.Strat), the software utilizes the discharge date to determine which rates to use.
- For add-ons (e.g., DSH, MPA, MHVA, Safety Net) or per diem reimbursements the actual dates of service for the accommodation codes are the criteria for each of these calculations. For example:
    - Inpatient confinement for COS 020:
        - Statement From and Statement Through: 9/25/2022 – 10/25/2022
        - Type of Bill: 111
        - Admit: 9/25/2022
        - Discharge: 10/25/2022
        - Room and Board Accommodation Code: 0120
        - Miscellaneous ancillary revenue codes (example 0250, 0300)
- For the dates of service 9/25/2022 – 9/30/2022 (i.e., prior to 10/1/2022), the DSH, MPA, MHVA, Safety Net add-ons will be based on FY 2022 published rates
- For dates of service 10/1/2022 – 10/25/2022 (i.e., on or after 10/1/2022) the DSH, MPA, MHVA, Safety Net add-ons will be based on FY 2023 published rates
- Per diem will always be the rate for the date of service on the claim.

NOTE: For all providers registered as HFS Provider Type 30 (General Acute Hospital) listed in the grid and scenarios depicted below, the examples described assume all authorizations for inpatient services have been obtained and approved with the appropriate MCO. This is only depicting instruction to the HFS Provider Type 30 on coding to bill claims to gain the reimbursement for the approved services indicated with such approval for services.

<table>
<tr><th>Services Rendered Inpatient</th><th>HFS Category of Service (COS)</th><th>Acceptable Taxonomies for COS</th><th>Description of Taxonomy</th><th>Type of Bill</th><th>Accommodation (Room and Board) Revenue Coding Definitions</th><th>Base Detail and HFS Reference Material</th></tr>
<tr>
<td>General Acute Care Accommodation Revenue Codes <u>Only</u> and any associated ancillary revenue code services incurred for the stay.

Note: General Acute services will Include any <u>Dialysis Inpatient</u> Revenue Codes defined as below:
<table>
<tr><td rowspan="8">080X-Inpatient Renal Dialysis</td><td>0800 - General</td></tr>
<tr><td>0801 - Inpatient hemodialysis</td></tr>
<tr><td>0802 - Inpatient peritoneal (non-CAPD)</td></tr>
<tr><td>0803 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)</td></tr>
<tr><td>0804 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)</td></tr>
<tr><td>0809 - Other</td></tr>
</table>
</td>
<td>020 – Inpatient Hospital Services (General) Only</td>
<td>Provider must bill one of the following:

282N00000X
282NC2000X
282NR1301X
282NW0100X
282NC0060X
281P00000X
281PC2000X
284300000X
286500000X
2865M2000X</td>
<td>

General Acute Care Hospital
General Acute Care Hospital - Children
General Acute Care Hospital – Rural
General Acute Care Hospital – Women
General Acute Care Hospital – CAH
Chronic Disease Hospital
Chronic Disease Hospital – Children
Special Hospital
Military Hospital
Military Hospital - Medical Center</td>
<td>111
112
113
114
115
121
122
123
124
125</td>
<td>General Acute Room and Board Revenue Coding is defined as follows:
<table>
<tr><th>High Level Revenue Code</th><th>Specific Revenue Codes</th></tr>
<tr><td>011X- Room and Board- Private- 1 Bed</td><td>0110- General
0111- Medical/Surgical/GYN
0112- OB
0113- Pediatric
0117-Oncology
0119-Other</td></tr>
<tr><td>012X- Room and Board -Semiprivate- 2 Beds</td><td>0120- General
0121- Medical/Surgical/GYN
0122- OB
0123- Pediatric
0127- Oncology
0129- Other</td></tr>
<tr><td>013X- Room and Board- -3 & 4 Beds</td><td>0130- General
0131- Medical/Surgical/GYN
0132- OB
0133- Pediatric
0137- Oncology
0139- Other</td></tr>
<tr><td>014X-Room and Board-Deluxe Private</td><td>0140- General
0141- Medical/Surgical/GYN
0142- OB
0143- Pediatric
0147- Oncology
0149- Other</td></tr>
<tr><td>015X-Room and Board-Ward</td><td>0150- General
0151- Medical/Surgical/GYN
0152- OB
0153- Pediatric
0157- Oncology
0159- Other</td></tr>
<tr><td>016X-Other Room and Board</td><td>0160- General
0164-Sterile
0169- Other</td></tr>
<tr><td>017X Nursery</td><td>0170- General
0171- Newborn Level I
0172- Newborn Level II
0173- Newborn Level III
0174- Newborn Level IV
0179- Other</td></tr>
</table>
</td>
<td>APR DRG Grouper reimbursement methodology for room and board and eligible ancillary revenue codes billed with the room and board revenue codes based on the patient's discharge date from COS 020 for the APR DRG base rate.

Per H201.21 Provider Participation Requirements of the HFS Hospital Handbook</td>
</tr>
</table>

<table>
<tr><th>Services Rendered Inpatient</th><th>HFS Category of Service (COS)</th><th>Acceptable Taxonomies for COS</th><th>Description of Taxonomy</th><th>Type of Bill</th><th>Accommodation (Room and Board) Revenue Coding Definitions</th><th>Base Detail and HFS Reference Material</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td><table><tr><td>020X- Intensive Care</td><td>0200- General
0201- Surgical
0202- Medical
0203- Pediatric
0206- Intermediate ICU
0207- Burn Care
0208- Trauma
0209- Other</td></tr><tr><td>021X- Coronary Care Unit</td><td>0210- General
0211- Myocardial Infarction
0212- Pulmonary Care
0213- Heart Transplant
0214- Intermediate CCU
0219- Other</td></tr></table></td><td></td></tr>
<tr><td>Physical Rehabilitation Care Accommodation Revenue Codes <u>Only</u> and any associated ancillary revenue code services incurred for the stay.
No General Acute Care Services Accommodation Revenue Codes</td><td>022 – Inpatient Hospital Services: Physical Rehabilitation</td><td>Provider must bill one of the following:

273Y00000X
283X00000X
283XC2000X</td><td>

Rehabilitation Unit
Rehabilitation Hospital
Rehabilitation Hospital - Children</td><td>111
112
113
114
115
121
122
123
124
125</td><td>Physical Rehabilitation Room and Board Revenue Codes are as follows:

<table><tr><th>High Level Revenue Code</th><th>Specific Revenue Codes</th></tr><tr><td>011X- Room and Board- Private- 1 Bed</td><td>0118- Rehabilitation</td></tr><tr><td>012X- Room and Board -Semiprivate- 2 Beds</td><td>0128- Rehabilitation</td></tr><tr><td>013X- Room and Board - 3 & 4 Beds</td><td>0138- Rehabilitation</td></tr><tr><td>014X- Room and Board – Deluxe Private</td><td>0148- Rehabilitation</td></tr><tr><td>015X- Room and Board- Ward</td><td>0158- Rehabilitation</td></tr></table>
If the hospital does not have COS 022 on their IMPACT registration, services billed with rehab room and board accommodation revenue codes will be denied.</td><td>Physical Rehabilitation Per Diem methodology for provider registered for COS 022 based on the patient’s service dates.

See section
Per H-262.5 Physical Rehabilitation Services and H201.23 Provider Participation Requirements of the Hospital Handbook</td></tr>
<tr><td>Psychiatric Care Accommodation Revenue Codes Only and any associated ancillary revenue code services incurred for the stay.

No General Acute Care Services</td><td>021 - Inpatient Hospital Psychiatric Services</td><td>Provider must bill one of the following:

273R00000X
or
283Q00000X</td><td>

Psychiatric Unit

Psychiatric Hospital</td><td>111
112
113
114
115
121
122
123
124
125</td><td>Psychiatric Care Room and Board Revenue Codes are as follows:

<table><tr><th>High Level Revenue Code</th><th>Specific Revenue Codes</th></tr><tr><td>011X- Room and Board- Private- 1 Bed</td><td>0114- Psychiatric</td></tr><tr><td>012X- Room and Board -Semiprivate- 2 Beds</td><td>0124- Psychiatric</td></tr><tr><td>013X- Room and Board - 3 & 4 Beds</td><td>0134- Psychiatric</td></tr><tr><td>014X- Room and Board – Deluxe Private</td><td>0144- Psychiatric</td></tr><tr><td>015X- Room and Board- Ward</td><td>0154- Psychiatric</td></tr><tr><td>020X- Intensive Care Psychiatric</td><td>0204- Psychiatric</td></tr></table></td><td>Per Diem reimbursement methodology for provider registered for COS 021 based on the patient’s service dates for to COS 021.

See section
Per H-262.4 Psychiatric Services and H201.22 Provider Participation Requirements of the Hospital Handbook</td></tr>
</table>

<table>
<tr><th>Services Rendered Inpatient</th><th>HFS Category of Service (COS)</th><th>Acceptable Taxonomies for COS</th><th>Description of Taxonomy</th><th>Type of Bill</th><th>Accommodation (Room and Board) Revenue Coding Definitions</th><th>Base Detail and HFS Reference Material</th></tr>
<tr><td>Accommodation Revenue Codes</td><td></td><td></td><td></td><td></td><td>Detoxification Room and Board Revenue Codes are as follows:

<table><tr><th>High Level Revenue Code</th><th>Specific Revenue Codes</th></tr><tr><td>011X- Room and Board- Private- 1 Bed</td><td>0116- Detoxification</td></tr><tr><td>012X- Room and Board -Semiprivate- 2 Beds</td><td>0126- Detoxification</td></tr><tr><td>013X- Room and Board - 3 & 4 Beds</td><td>0136- Detoxification</td></tr><tr><td>014X- Room and Board – Deluxe Private</td><td>0146- Detoxification</td></tr><tr><td>015X- Room and Board- Ward</td><td>0156- Detoxification</td></tr></table>
If the hospital does not have COS 021 on their IMPACT registration, these services billed with psychiatric or detoxification room and board accommodation revenue codes will be denied.</td><td></td></tr>
<tr><td>General Acute Care Accommodation Revenue Codes

<u>and</u>

Physical Rehabilitation Care Accommodation Revenue Codes</td><td colspan="3">These two COS cannot be billed by the provider on the same claim.

If the provider is registered for both COS 020 and COS 022, the provider must split the claim into two claims. If COS 020 and 022 are billed on the same claim, the claim will be denied.

The General Acute Services portion of the patient stay should be billed with the general acute accommodation and ancillary revenue codes incurred during the patient stay on the medical unit using an appropriate COS 20 taxonomy code.

A second claim should be submitted with the appropriate Physical Rehabilitation Care Accommodation revenue codes and ancillary revenue codes for the services rendered on the rehabilitation unit with an appropriate COS 22 taxonomy code.

If the Hospital (HFS Provider Type 30) does not have COS 022 in IMPACT. The rehabilitation portion of the claim will not be payable and the claim will deny.</td><td>111
112
113
114
115
121
122
123
124
125</td><td>Any coding combinations of General Acute accommodation revenue codes defined in row 1 of this table
Any revenue codes for Physical Rehabilitation Services found in row 2 of this table.

General Acute accommodation revenue codes and Physical Rehabilitation accommodation revenue codes CANNOT be combined onto one claim.

Per H-262.5 Physical Rehabilitation Services of the Hospital Handbook:
Physical rehabilitation inpatient services provided to patients during an acute stage of a disabling illness or injury are considered to be general inpatient services. When the acute stage ends and the patient no longer requires acute hospital care but does require comprehensive inpatient physical rehabilitation services, such services may be provided only by hospitals enrolled for Category of Service 22, Inpatient Hospital Services (Physical Rehabilitation).</td><td>Any provider billing for COS 022 must be registered in IMPACT for this COS.

General acute services are APR DRG reimbursement methodology and Physical Rehabilitation services are per diem.</td></tr>
</table>

Services Rendered Inpatient	HFS Category of Service (COS)	Acceptable Taxonomies for COS	Description of Taxonomy	Type of Bill	Accommodation (Room and Board) Revenue Coding Definitions	Base Detail and HFS Reference Material
General Acute Care Accommodation Revenue Codes **And/Or** **Psychiatric Care Accommodation Revenue Codes on the same claim** **and** **Psychiatric Primary Diagnosis as determined by HFS**	COS 020 – Inpatient Hospital Services (General) If a provider is registered with COS 020 **without also being registered with COS 021**, three (3) emergency psychiatric days as a general inpatient service are allowed for a maximum period of three (3) days. The provider can use the General Acute taxonomies to bill those services under COS 020 (refer to row 1 of this table). **If a provider has COS 021 in addition to COS 020**, a second claim would need to be sent for the psychiatric care after the first 3 days that represents all the accommodation and ancillary revenue codes for the psychiatric care in the psychiatric unit. A Psychiatric taxonomy code and Psychiatric revenue codes must be used to bill COS 021 services. These services would be paid via psychiatric per diems. In this scenario, the provider must split the claim into two claims. NOTE: If the provider does NOT have COS 021, it is expected the hospital would find placement for the patient in a hospital enrolled to provide psychiatric services for Illinois Medicaid (COS 21). • If the Primary Diagnosis is a psychiatric code and the covered days are **3 or less**, the claim will be considered via APR DRG reimbursement methodology as HFS COS 20. • If the Primary Diagnosis is a psychiatric code and the covered days are not 3 or less, the claim can be subject to denial. Providers can review HFS' list of psychiatric diagnosis codes here.			111 112 113 114 115 121 122 123 124 125	Any coding combinations of Room and Board General Acute revenue codes defined in row 1 of this table with any revenue codes for Psychiatric Services found in row 3 of this table equals General Acute Services with Psychiatric Care Services. If the provider does NOT have an IMPACT registration for COS 021, 3 emergency psych days would be allowed under registration for COS 020. Without a COS 21 registration, the 4th day and beyond of psychiatric would be non-covered. **Per H-262.4 Psychiatric Services of the** Hospital Handbook: Inpatient psychiatric services are those services provided to patients who need short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder. Except as specified below, inpatient services for psychiatric care and treatment are not considered to be general inpatient services and may be provided only by hospitals enrolled for Category of Service 21, Inpatient Hospital Services (Psychiatric). All inpatient psychiatric services billed as Category of Service 21 are exempt from DRG reimbursement and will be reimbursed at a per diem rate. Inpatient psychiatric services may be provided by a general hospital or by a psychiatric hospital enrolled with the department for Category of Service 21. Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, inpatient psychiatric services provided by psychiatric hospitals are covered services only for patients ages 65 and over and patients under age 21, or up to age 22 for those receiving these services immediately prior to attaining age 21. A general care hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service (Category of Service 20) only on an emergency basis for a maximum period of three (3) days. During this period, the hospital must seek placement of patient in a hospital enrolled to provide psychiatric services. Such services are subject to review by the department or its designated agent.	Acute Care Medical APR DRG if the provider is registered for HFS COS 020 only for the first 3 days of psychiatric care for initial stabilization if required so the patient can move to the next level of care based the base rate for the discharge date of COS 020. If provider has HFS COS 021, after 3 days of emergency treatment in a general acute hospital (HFS Provider Type 30), the provider is reimbursed per diem based on the patient's admission date to COS 021.
General Acute, Psychiatric, and Physical Rehab	Not expected scenario	Not expected scenario	Not expected scenario Claim should deny as this is not an expected scenario, and the claim would have to be reviewed.	111 112 113 114 115 121 122 123 124 125	Not expected scenario – If it were to happen provider would need to be registered for all three and three claims would be expected for each COS portion of the confinement.	Not expected scenario

SEE CLAIM EXAMPLES ON FOLLOWING PAGES

CLAIM EXAMPLES

HOSPITAL CASE 1 - Provider Billed a Primary Diagnosis Code of F50.01 Anorexia Nervosa:

Bill Type: 111
Statement From and Statement To: 1/12/2021 – 1/18/2021
Provider is registered in IMPACT for COS 020 and COS 021
Provider Taxonomy Billed: General Acute - 282N00000X
Primary diagnosis: F50.01 Anorexia nervosa, restricting type
Billed for 6 days using Rev Code 214 (Intermediate CCU)

RevCode	Unit	Line Charge Amount
214	6	28200
250	45	576
300	7	264
301	20	2087
306	1	128
307	1	48
730	3	1098

POA Indicator		Diagnosis Codes	
Admitting	N/A	**Admitting**	R634 - Abnormal weight loss
Primary	Y	**Primary**	F5001 - Anorexia nervosa, restricting type
2	Y	**2**	F5002 - Anorexia nervosa, binge eating/purging type
3	Y	**3**	E43 - Unspecified severe protein-calorie malnutrition
4	Y	**4**	K5900 - Constipation, unspecified
5	N	**5**	F410 - Panic disorder [episodic paroxysmal anxiety]
6	Y	**6**	F419 - Anxiety disorder, unspecified
7	Y	**7**	K219 - Gastro-esophageal reflux disease without esophagitis
8	Y	**8**	Z20822 - Contact with and (suspected) exposure to COVID-19
		9	Z818 - Family history of other mental and behavioral disorders
		10	Z9049 - Acquired absence of other specified parts of digestive tract

Summary:

- This diagnosis is one of HFS' principal psychiatric diagnosis codes (Attachment B) for medical services under Category of Service 20 or psychiatric services Category of Service 21. If a code from this list is used as the principal diagnosis code, general care hospitals that are not enrolled for COS 21 may only bill for a maximum of three days of emergency psychiatric care using COS 20.
- **Claim billed incorrectly with general acute care taxonomy. Provider is registered with COS 021 and should bill using a psychiatric taxonomy code, either 273R00000X (psychiatric unit) or 283Q00000X (psychiatric hospital) and will be reimbursed by psychiatric per diems.**
- **This claim will be denied by the MCO as billing with the incorrect General Acute Care taxonomy with a psychiatric diagnosis code.**
- **This is a psychiatric per diem stay because of a principal psychiatric diagnosis code, regardless of the accommodation revenue code.**

HOSPITAL CASE 2- Provider Billed a Primary Diagnosis Code F44.4: Conversion disorder with motor symptom or deficit:

Bill Type: 111
Statement From and Statement To: 1/25/2021-1/26/2021
Provider is registered in IMPACT for C0S 020 only, and is NOT registered for COS 021.
Provider Taxonomy Billed: General Acute - 282N00000X

Principal Diagnosis Code: F44.4 Conversion Disorder w motor symptom or deficit

Billed for 1 day using Rev Code 120 (General Room and Board)

RevCode	Unit	Line Charge Amount
120	1	1869
250	69	845.2
300	9	408
430	1	662
460	4	424
636	14	698.05

POA Indicator		Diagnosis Codes	
Admitting	N/A	**Admitting**	F444 - Conversion disorder with motor symptom or deficit
Primary	Y	**Primary**	F444 - Conversion disorder with motor symptom or deficit
2	Y	**2**	F3181 - Bipolar II disorder
3	Y	**3**	I10 - Essential (primary) hypertension
4	Y	**4**	E119 - Type 2 diabetes mellitus without complications
5	Y	**5**	R531 - Weakness
6	Y	**6**	M545 - Low back pain
7	Y	**7**	E669 - Obesity, unspecified
		8	Z6839 - Body mass index [BMI] 39.0-39.9, adult
9	Y	**9**	G40909 - Epilepsy, unspecified, not intractable, without status epilepticus
10	Y	**10**	G43909 - Migraine, unspecified, not intractable, without status migrainosus
11	Y	**11**	F17210 - Nicotine dependence, cigarettes, uncomplicated
12	Y	**12**	J45909 - Unspecified asthma, uncomplicated
13	Y	**13**	Z20822 - Contact with and (suspected) exposure to COVID-19
		14	Z8669 - Personal history of other diseases of the nervous system and sense organs
		15	Z91410 - Personal history of adult physical and sexual abuse

Summary:

- This diagnosis is one of HFS' principal psychiatric diagnosis codes (Attachment A). If a code from this list is used as the principal diagnosis code, general acute care hospitals that are not enrolled for COS 21 may only bill for a maximum of three days of emergency psychiatric care using COS 20.
- **This hospital is only registered for COS 020 and therefore can bill up to a maximum of three days of psychiatric care. A General Acute taxonomy may be used in this instance.**
- **This claim is billed correctly and would be paid according to APR DRG rates.**

HOSPITAL CASE 3: Provider Billed a Primary Diagnosis Code F0150: Vascular dementia without behavioral disturbance.

Bill Type: 111
Statement From and Statement To: 1/7/2021-1/15/2021
Provider is registered in IMPACT for C0S 020 only, and is NOT registered for COS 021.
Provider Taxonomy Billed Taxonomy: General Acute - 282N00000X

Principal Diagnosis Code: F01.50 Vascular dementia without behavioral disturbance

Billed for 4 days using Rev Code 111 (Medical/Surgical/GYN -Private Room) and 4 days using Rev Code 121 (Medical/Surgical/GYN- Semiprivate)

RevCode	Unit	Line Charge Amount
111	4	8912
121	4	8312
250	81	1265.59
300	4	163
301	25	1860
302	1	65
305	4	117
307	1	16
320	1	156
351	1	1138
420	3	373
730	2	144

POA Indicator		Diagnosis Codes	
Admitting	N/A	**Admitting**	R4182 - Altered mental status, unspecified
Primary	Y	**Primary**	F0150 - Vascular dementia without behavioral disturbance
2	Y	**2**	I21A1 - Myocardial infarction type 2
3	Y	**3**	I5023 - Acute on chronic systolic (congestive) heart failure
4	Y	**4**	F05 - Delirium due to known physiological condition
5	Y	**5**	I4820 - Chronic atrial fibrillation, unspecified
6	Y	**6**	G9349 - Other encephalopathy
7	Y	**7**	R4182 - Altered mental status, unspecified
8	Y	**8**	I110 - Hypertensive heart disease with heart failure
9	Y	**9**	F600 - Paranoid personality disorder
10	Y	**10**	E559 - Vitamin D deficiency, unspecified
11	Y	**11**	I739 - Peripheral vascular disease, unspecified
12	Y	**12**	J45909 - Unspecified asthma, uncomplicated
13	Y	**13**	N400 - Benign prostatic hyperplasia without lower urinry tract symp
14	Y	**14**	E032 - Hypothyroidism due to medicaments and other exogenous substances
15	Y	**15**	D649 - Anemia, unspecified
		16	Z8616 - Personal history of COVID-19
17	Y	**17**	T462X5A - Adverse effect of other antidysrhythmic drugs, initial encounter
		18	Z79890 - Hormone replacement therapy
		19	Z79899 - Other long term (current) drug therapy
		20	Z8546 - Personal history of malignant neoplasm of prostate

Summary:

- This diagnosis is one of HFS' principal psychiatric diagnosis codes (Attachment B) for medical services under Category of Service 20 or psychiatric services Category of Service 21. If a code from this list is used as the principal diagnosis code, general care hospitals that are not enrolled for COS 21 may only bill for a maximum of three days of emergency psychiatric care using COS 20.
- **This claim will be paid for the first three days via APR DRG. The 4th day and beyond may not be paid due to the diagnosis code of F01.50. As this is a psychiatric diagnosis code, the provider should have placed the patient in a hospital registered with a COS 021 for a stay beyond 3 days.**
- **MCOs could deny any days after the initial 3 days without a proper placement or medical approval from clinical teams.**

HOSPITAL CASE 4: Provider Billed a Primary Diagnosis Code of F11.23 – Opioid Dependence with withdrawal

Bill Type: 111
Statement From and Statement To: 7/28/2021 – 7/31/2021
Provider is registered in IMPACT for C0S 020 and COS 021.
Provider Taxonomy Billed: General Acute - 282N00000X

Principal Diagnosis Code: F11.23 Opioid Dependence with withdrawal
Billed for 3 DAYS using Rev Code 116 (Private Detox)

Rev Code	Unit	Line Charge Amount
116	3	$3,747.00
259	19	$58.31
272	1	$20.00
300	6	$824.00

POA Indicator		Diagnosis Codes	
Admitting	N/A	**Admitting**	F1123 - Opioid dependence with withdrawal
Primary	Y	**Primary**	F1123 - Opioid dependence with withdrawal
2	Y	**2**	F419 - Anxiety disorder, unspecified
3	Y	**3**	F329 - Major depressive disorder, single episode, unspecified
4	Y	**4**	F909 - Attention-deficit hyperactivity disorder, unspecified type
5	Y	**5**	F1020 - Alcohol dependence, uncomplicated
6	Y	**6**	F17210 - Nicotine dependence, cigarettes, uncomplicated
		7	Z590 - Homelessness

Summary:

- This diagnosis is one of HFS' principal psychiatric diagnosis codes (Attachment B) for medical services under Category of Service 20 or psychiatric services Category of Service 21. If a code from this list is used as the principal diagnosis code, general care hospitals that are not enrolled for COS 21 may only bill for a maximum of three days of emergency psychiatric care using COS 20.
- **Claim billed incorrectly with General Acute taxonomy when the provider is registered with COS 021. This claim would be denied.**
- **Because the principal diagnosis is psychiatric and the provider is registered with COS 021, the provider should have billed using the Psychiatric taxonomy and would be paid via psychiatric per diem reimbursement.**

HOSPITAL CASE 5: Provider Billed a Primary Diagnosis Code of F32.3 – Major depressive disorder, single episode, severe psychotic features

Bill Type: 111
Statement From and Statement To: 1/9/2021 – 1/14/2021
Provider is registered in IMPACT for C0S 020 and COS 021.
Provider Taxonomy Billed: General Acute - 282N00000X

Principal Diagnosis Code: F32.3 Major depressive disorder, single episode, severe with psychotic features

Billed for 5 days using Rev Code 111 (Room and Board – Private)

Rev Code	Unit	Charge Amount
111	5	$ 16,365.00
250	49	$ 1,677.50
260	2	$ 1,406.00
300	24	$ 4,546.00
301	3	$ 1,272.00
324	1	$ 603.00
460	6	$ 834.00
730	1	$ 445.00
900	1	$ 637.00

POA Indicator		Diagnosis Codes	
Admitting	N/A	**Admitting**	R440 - Auditory hallucinations
Primary	Y	**Primary**	F323 - Major depressive disorder, single episode, severe with psychotic features
2	Y	**2**	U071 - COVID-19
3	Y	**3**	D72819 - Decreased white blood cell count, unspecified
4	Y	**4**	I959 - Hypotension, unspecified
5	Y	**5**	R45851 - Suicidal ideations
6	Y	**6**	F419 - Anxiety disorder, unspecified
7	Y	**7**	E860 - Dehydration
8	Y	**8**	G4700 - Insomnia, unspecified
		9	Z91410 - Personal history of adult physical and sexual abuse

Summary:

- This diagnosis is one of HFS' principal psychiatric diagnosis codes (Attachment A) for psychiatric services under COS 21. If a code from this list is used as the principal diagnosis code, general care hospitals that are not enrolled for COS 21 may only bill for a maximum of three days of emergency psychiatric care using COS 20.
- **Claim billed incorrectly with General Acute taxonomy when the provider is registered with COS 021. This claim will be denied.**
- **Because the principal diagnosis is psychiatric and the provider is registered with COS 021, the provider should have billed using the Psychiatric taxonomy and would be paid via psychiatric per diem reimbursement.**

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:

<table>
<tr><th>IF...</th><th>THEN...</th></tr>
<tr><td>Member was seen for only outpatient services on a single day.</td><td>Statement covered dates would be the same and no admission date would be billed.
<table>
<tr><th>From</th><th>Through</th><th>Admission Date</th></tr>
<tr><td>030119</td><td>030119</td><td></td></tr>
</table></td></tr>
<tr><td>Member was first seen in the Emergency Department / Observation, then admitted later that day and provider is billing a single claim.</td><td>Statement covered dates would begin the day the member was first seen in the Emergency Department and admission date would be the same.
<table>
<tr><th>From</th><th>Through</th><th>Admission Date</th></tr>
<tr><td>030119</td><td>030419</td><td>030119</td></tr>
</table></td></tr>
<tr><td>Member was first seen in the Emergency Department (ED)/ Observation, then admitted and provider is billing two separate claims.</td><td>Hospitals have the option to bill, in addition to the inpatient claim, one outpatient claim containing the emergency room charge or the observation room charge only. All ancillary services related to the emergency or observation department services are reported on the inpatient claim.
First Claim:
Statement covered dates would include only the days member was in the Emergency Department / Observation with no admission date.
Second Claim:
Statement covered day would begin on the next day member was admitted. Admission date would match that date. Correct and valid admission source code should be submitted.
<table>
<tr><th>Claim</th><th>From</th><th>Through</th><th>Admission Date</th></tr>
<tr><td>Claim 1</td><td>030119</td><td>030119</td><td></td></tr>
<tr><td>Claim 2</td><td>030219</td><td>030619</td><td>030219</td></tr>
</table></td></tr>
</table>

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
- Rate Code
- Recurring Monthly Income
- Other Insurance Payment
- Newborn Birth Weight
- Epogen Units
- Medicaid Covered Days
- Medicaid Non-Covered Days

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 (Non-Covered Days)	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. **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 (click here and scroll to Appendix H-3 to view the list). For dates of service **prior to 4/1/24**, these codes ***should not*** be billed on an Illinois Medicaid claim. Billing with these codes will result in a claim rejection.

Effective with dates of service starting 4/1/24, the non-covered revenue codes should be billed to the MCOs to represent a full claim experience for the member. The MCOs will not pay these codes, but they can be included on the claim and will not result in a claim rejection.

It is the expectation that 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
OB	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:

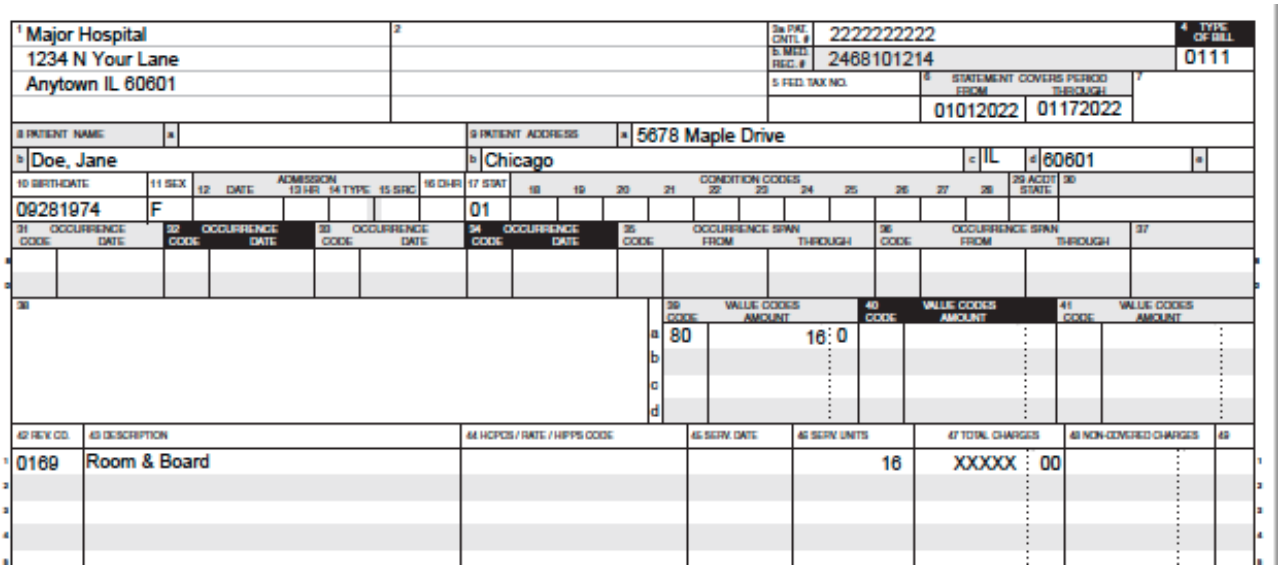
- C1 would be used if the entire stay was fully covered.
- C3 would be used when non-covered days were reported as well.
- Condition codes are required for the claim to process. The absence of these condition codes will result in a claim denial.

Aetna Better Health of Illinois Only Requirement:

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.

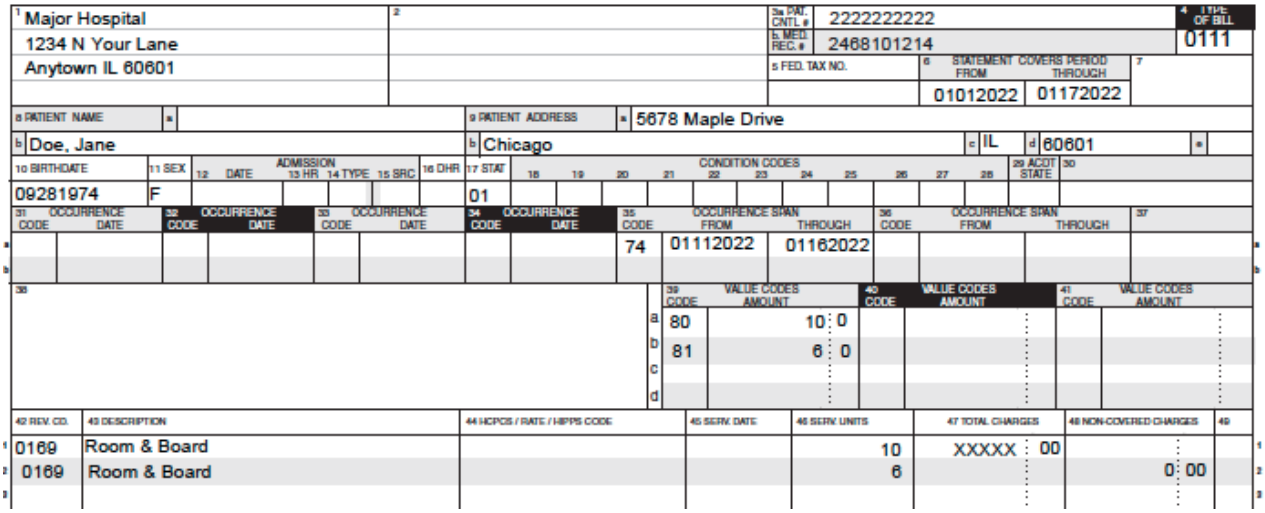
Example 1: Covered Days Only

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
  - 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
  - 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 crosses calendar months.

Hospitals reimbursed with the DRG methodology cannot submit interim claims. A single claim for the entire period covering admit through discharge should be submitted, unless the category of service (COS) changes during the stay. 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.

Guidelines for Interim Claims

- Patient status 30 must be billed for interim claims. Interim claims are defined by using Bill Frequency Type Code equal to 2 or 3.
- 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.

Descriptions for covered/non-covered day calculations (Value Code 80/81):

1. **Bill Frequency Type Code = 1:** Admit through Discharge Claim = (DOS Thru Date – DOS from Date). This is NOT an interim claim.
   - Bill Frequency Type Code 1 can be billed with less than 30 days and CAN cross months.
2. **Bill Frequency Type Code = 2**: Interim-First Claim = (DOS To Date – DOS From Date) +1
   - Bill Frequency Type Code 2 can be billed for less than a full calendar month beginning with the admission date but CANNOT cross months. If the patient is admitted on the last day of the month, the last day of the month can be billed as 1 day, with the "Statement From" and "Statement To" dates both equal to the last day of the month.

3. **Bill Frequency Type Code = 3**: Interim-Continuing Claim = (DOS To Date – DOS From Date) +1
   - Bill Frequency Type Code 3 cannot be billed for less than a full calendar month and CANNOT cross months.
4. **Bill Frequency Type Code = 4:** Interim-Final Claim = (DOS To Date – DOS From Date)
   - Bill Frequency Type Code 4 can be billed with less than a full calendar month ending with the discharge date but CANNOT cross months.

Refer to the detailed examples below.

Example 1: Interim Claiming for member with a significant length of stay where member is NOT admitted on the last day of the month:

- Member is admitted on 3/7/2022.
- No discharge planned for the near future. Member will be inpatient longer than 30 days for a service reimbursed under the per diem reimbursement methodology.
- Patient is discharged to a skilled nursing facility on 7/4/2022.

In this scenario, the hospital would submit interim bills as follows:

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
112	3/7/2022	3/31/2022	3/7/2022	Still Patient	25
113	4/1/2022	4/30/2022	3/7/2022	Still Patient	30
113	5/1/2022	5/31/2022	3/7/2022	Still Patient	31
113	6/1/2022	6/30/2022	3/7/2022	Still Patient	30
114	7/1/2022	7/4/2022	3/7/2022	7/4/2022	3

Example 2: Interim Claiming when Admit Date is on the last day of the month

- Member admitted on 5/31/2022.
- No discharge planned for the near future. Member will be inpatient 41 days for a service reimbursed under the per diem reimbursement methodology.
- Patient is discharged to a skilled nursing facility on 7/11/2022.

In this scenario, because claims cannot cross months, the hospital would submit interim claims as follows:

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
112	5/31/2022	5/31/2022	5/31/2022	Still Patient	1
113	6/1/2022	6/30/2022	5/31/2022	Still Patient	30
114	7/1/2022	7/11/2022	5/31/2022	7/11/2022	10

Example 3: Interim Claiming when Admit Date is last day of the month and member is inpatient 20 days

- Member admitted on 9/30/2022
- **Patient was NOT inpatient longer than 30 days** for a service reimbursed under the per diem reimbursement methodology.
- Patient is discharged to a skilled nursing facility on 10/20/2022.

This scenario can be billed as an interim claim (see 3a) OR as an admit-through-discharge (see 3b) claim since the provider is reimbursed via a per diem reimbursement methodology and patient was admitted on the last day of the month.

3a. Interim Claim Option: Admit Date on the last day of the month.

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
112	9/30/2022	9/30/2022	9/30/2022	Still Patient	1
114	10/1/2020	10/20/2022	9/30/2022	10/20/2022	19

3b. Admit-through-Discharge Claim Option:

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
111	9/30/2022	10/20/2022	9/30/2022	10/20/2022	20

Example 4: . Billing Scenario when Admit Date is NOT last day of the month and member is inpatient 24 days:

Incorrect billing option: When Frequency Bill Type = 2 and the 'Statement To' Date Is NOT equal to the last day of the month, the claim would be denied by HFS FFS (U14 denial code) and by the MCOs. The Bill Type 112 claim does NOT have a 'Statement To date equal to the last day of the month.

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
112	9/26/2022	10/5/2022	9/26/2022	Still Patient	10
114	10/6/2020	10/20/2022	9/26/2022	10/20/2022	14

Correct billing options would be:

4a. Interim Claim Option - Admit not on the last day of the month.

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
112	9/26/2022	9/30/2022	9/26/2022	Still Patient	5
114	10/1/2020	10/20/2022	9/26/2022	10/20/2022	19

4b. Admit thought discharge claim for the total days stayed would also be an acceptable submission in this scenario for a provider who is reimbursed at a per diem reimbursement methodology in Illinois Medicaid:

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
111	9/26/2022	10/20/2022	9/26/2022	10/20/2022	24

Example5: Incorrect Interim Claiming for Bill Types 113 or 114 (Bill Type Frequency 3 or 4) - Admit Date Error

5a. Bill Type 113 – Continuing Interim Claim

This example is an incorrect billing scenario that will be denied by both HFS FFS (C91 denial) and the MCOs. On an interim claim the admission date must be the actual admission date and will never be the same as the 'Statement From' date' in the Statement Covers Period. Using Bill Type 113 implies a continuing interim claim; thus, the admission date must be before the 'Statement From' date.

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Room & Board Days
113	3/8/2023	3/31/2023	3/8/2023	Still Patient	24

5b. Bill Type 114 – Final Interim Claim

This example is an incorrect billing scenario that will be denied by both HFS FFS (C91 denial) and the MCOs. The admission date must be the actual admission date and will never be the same as the 'Statement From' date' in the Statement Covers Period. Using Bill Type 114 implies a FINAL interim claim; thus, the admission date must be before the 'Statement From' date.

Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Status	Room & Board Days
114	4/24/2023	5/22/2023	4/24/2023	01	28

Example 6: Additional Exception to the 30-Day Interim Billing Process - Medicaid Coverage Changes During Inpatient Stay

The examples outline how to bill when MCO or FFS coverage changes during the inpatient stay. These claims must be billed as admit-through-discharge (cannot be billed interim) indicating an occurrence span 74 for the non-covered days payable by the alternate payer (Illinois Medicaid FFS or another MCO).

6a: MCO to FFS coverage during stay

- Member was admitted on 5/10/23 under managed care coverage. The managed care coverage ended on 5/31/23.
- On 6/1/2023, the patient is enrolled into Illinois Medicaid FFS. The patient was discharged on 6/18/23 (39 days total).
- Total inpatient stay of 39 days.
- Two claims are required, one for the MCO payer and another for Illinois Medicaid FFS.

Payer	Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Occurrence Span code 74 non-covered days	Value Code 81 (Non-Covered days)	Value Code 80 (Covered Days)
MCO	111	05/10/23	6/18/2023	05/10/23	06/18/23	6/1/23 – 6/17/23	17	22
FFS	111	05/10/23	6/18/2023	05/10/23	06/18/23	5/10/23 -5/31/23	22	17

6b: Admission on last day of the month and coverage changes during stay

- Member is admitted on the last day of the month (5/31/2023) with FFS coverage.
- FFS coverage also terms on 5/31/2023.
- Member coverage switches to an MCO effective 6/1/2023.

Payer	Bill Type	'Statement From' Date	'Statement To' Date	Admit Date	Discharge Date	Occurrence Span code 74 non-covered days	Value Code 81 (Non-Covered Days)	Value Code 80 (Covered Days)
FFS	111	05/31/23	7/11/2023	05/31/23	07/11/23	6/1/23 – 7/10/23	40	1
MCO	111	05/31/23	7/11/2023	05/31/23	07/11/23	5/31/23 – 5/31/23	1	40

Providers should be aware the scenarios denoted in example 6 may require working with their provider representative at the impacted MCO to ensure clean processing through claim systems.

See **Appendix L: Coordination of Benefits (COB)/Third Party Liability (TPL)** in the manual for scenarios with coverage scenarios that may also include commercial payors for proper claiming and coordination.

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

a) 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.

b) 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.

c) 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 all services (including the MRI) to Member Smith's MCO. Hospital B will not 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 any post-stabilization services as 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

i. 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 principal 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.
Abortion Condition Code	Hospital services for abortions must be billed with the abortion "AH" 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.
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.

II. 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 an 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.

Effective with dates of service beginning 7/1/2014, all outpatient/ambulatory claims are grouped and reimbursed through 3M™EAPG 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 service[9]; 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)
- 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.

APG 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 was eliminated. Hospitals are no longer required to bill as indicated in the 'NON-APL Billing Section' outlined in Section D 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*:

Taxonomy	Descriptions
282N00000X	General Acute Care Hospital
282NC2000X	General Acute Care Hospital - Children
281P00000X	Chronic Disease Hospital

Taxonomy	Descriptions
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
282NC0060X	General Acute Care Hospital – CAH
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.

ii. 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 the table 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).

Revenue Codes with associated HCPCS Codes

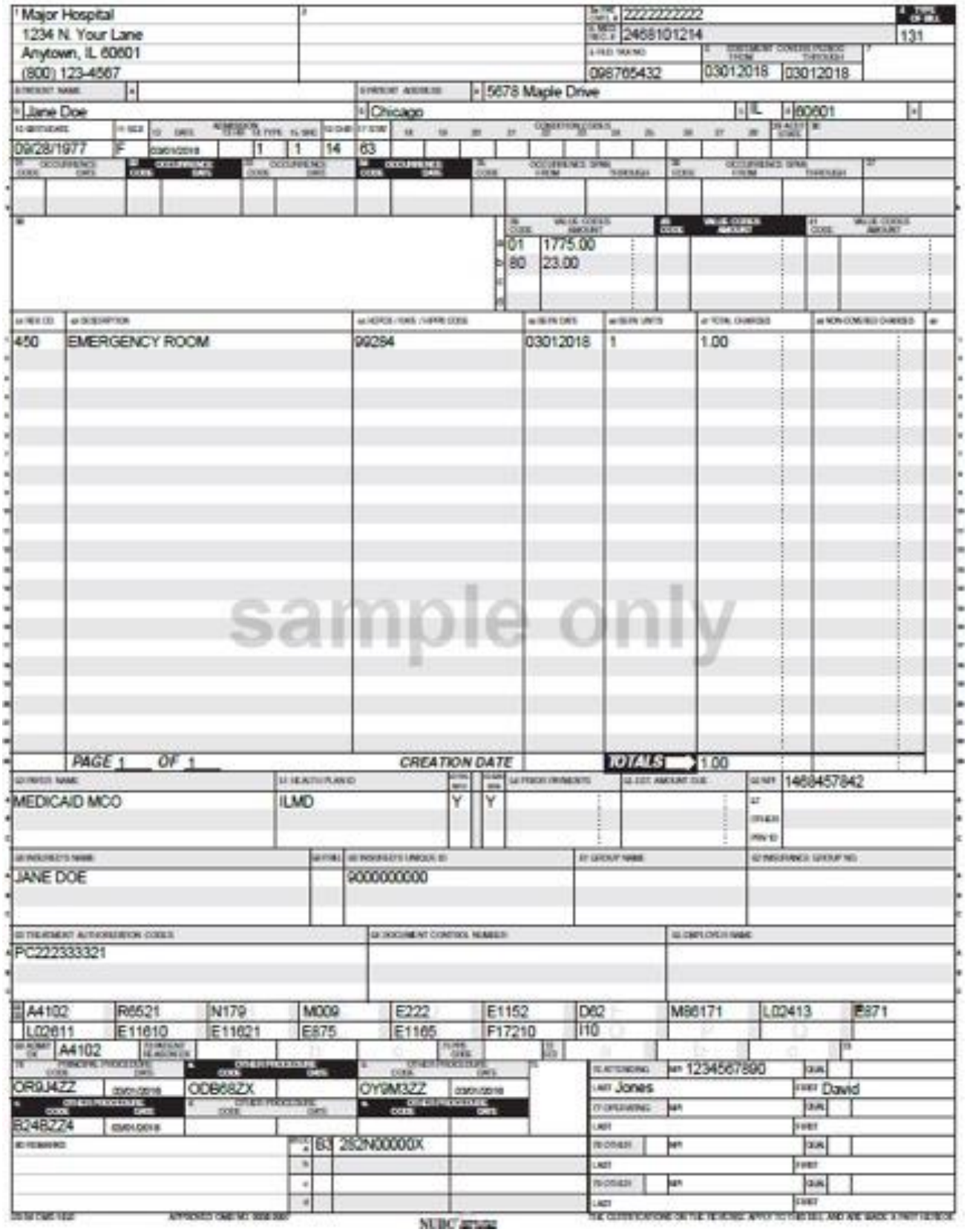
Revenue Code	Associated HCPCS Codes
0450	99284, 99285, 99291, G0383, G0384
0456	99282, 99283, G0381, G0382
0451	99281, G0380

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.

ED Outpatient Claim (Bill Type = 131)



iii. 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.

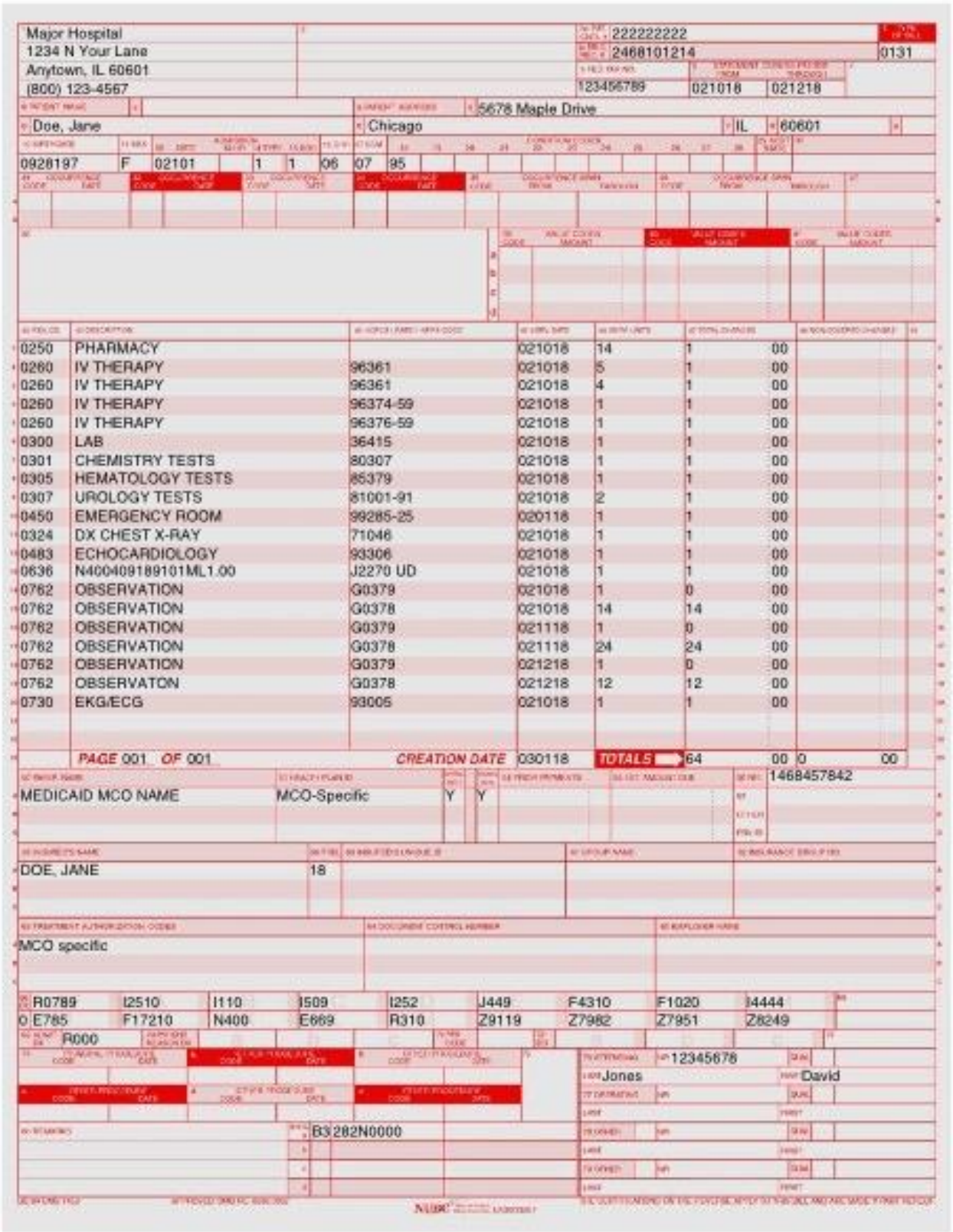
Billing of observation services for dates of service ON OR AFTER 7/1/2020:

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
0762	G0378

Both revenue lines above are required on an observation claim.

Observation Claim



Major Hospital
1234 N Your Lane
Anytown, IL 60601
(800) 123-4567

222222222
2468101214
0131
123456789 021018 021218

Doe, Jane | 5678 Maple Drive | Chicago | IL | 60601

0928197 F 02101 1 1 06 07 95

0250	PHARMACY		021018	14	1	00	
0260	IV THERAPY	96361	021018	5	1	00	
0260	IV THERAPY	96361	021018	4	1	00	
0260	IV THERAPY	96374-59	021018	1	1	00	
0260	IV THERAPY	96376-59	021018	1	1	00	
0300	LAB	36415	021018	1	1	00	
0301	CHEMISTRY TESTS	80307	021018	1	1	00	
0305	HEMATOLOGY TESTS	85379	021018	1	1	00	
0307	UROLOGY TESTS	81001-91	021018	2	1	00	
0450	EMERGENCY ROOM	99285-25	020118	1	1	00	
0324	DX CHEST X-RAY	71046	021018	1	1	00	
0483	ECHOCARDIOLOGY	93306	021018	1	1	00	
0636	N400409189101ML1.00	J2270 UD	021018	1	1	00	
0762	OBSERVATION	G0379	021018	1	0	00	
0762	OBSERVATION	G0378	021018	14	14	00	
0762	OBSERVATION	G0379	021118	1	0	00	
0762	OBSERVATION	G0378	021118	24	24	00	
0762	OBSERVATION	G0379	021218	1	0	00	
0762	OBSERVATON	G0378	021218	12	12	00	
0730	EKG/ECG	93005	021018	1	1	00	
	PAGE 001 OF 001	CREATION DATE	030118	TOTALS	64	00	0 00

MEDICAID MCO NAME | MCO-Specific | Y | Y | 1468457842

DOE, JANE | 18

MCO specific

R0789 I2510 I110 I509 I252 J449 F4310 F1020 I4444
E785 F17210 N400 E669 R310 Z9119 Z7982 Z7951 Z8249
R000

12345678 Jones David

B3282N0000

iv. 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 Psychiatric Free-Standing Hospitals 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)
    a. 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.
    b. 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.
- Psychiatric Clinic Type B intensive outpatient program (IOP) claims must be coded with Revenue code 0913 (and HCPCS code S9480).

- Psychiatric Clinic Type B Partial hospitalization program (PHP) 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.

v. Series Billing for Claims

a) 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. 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

Series-Billable Revenue Codes	
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
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

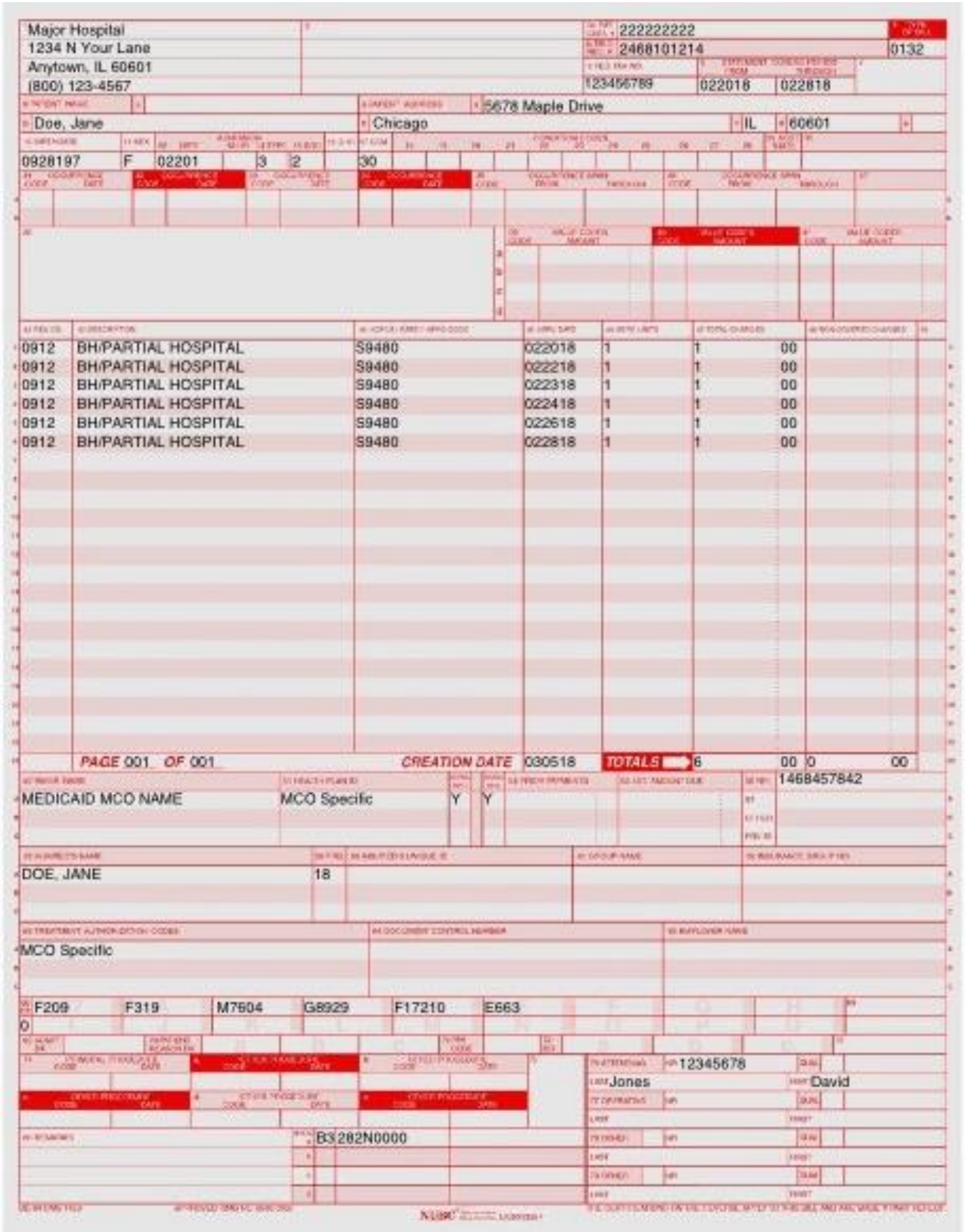
Series bills may be submitted for up to a maximum of thirty-one (31) days from the date of the first visit. If the series is longer than 31 days, the claim must be split. The date range for a series claim must include the beginning and ending service dates for the time period being billed. **DO NOT** 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.

Sample Series Billed Claim:



b) 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.

vi. Billing with Different Taxonomies for Multiple Categories of Service

a) 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 **Provider Types/COS/Taxonomy Codes**) the days will need to be split across claims, as only one Taxonomy Code can be billed on a claim.

Example: 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)	**0**XXXXXXXXXX
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:

	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			1
2	0636	N400409113403ML10	J2270	102918	10	1 00			2
3	0636	N400378031593ML1	Q0162	102918	5	3 00			3
4									4

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:

Illinois Department of Healthcare and Family Services
Practitioner Fee Schedule Effective 10/01/2018 Updated 10/22/2018

This fee schedule applies to charges submitted by the following providers: Advanced Practice Nurses, Dentists providing medical services, Fee-For-Service Hospitals, Imaging Centers, Independent Diagnostic Testing Facilities (IDTFs), Independent Laboratories, Local Health Departments, Optometrists providing medical services, Physicians, and Portable X-ray Companies. Encounter Rate Clinics (ERCs), Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHCs) should utilize this fee schedule for a listing of covered services billable as detail codes. Please note the appearance of a code on this fee schedule does not guarantee payment. Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. See Handbook for Providers of Medical Services, Topic 104 and Practitioners Handbook, Section 204 for additional exclusions. Updates are based on periodic modifications to the HCPCS/CPT code set. CPT codes and descriptions only are copyright 2018 by the American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply. National Correct Coding Institute (NCCI) edits apply. *2.7% rate reductions shown in a separate column do not apply to: Physicians, Dentists, Advanced Practice Nurses, FQHCs, RHCs, ERCs, or Local Health Departments.

														Add-On			Rate reduced by 2.7%	
Procedure Code	Note	Prog Cov	Eff Date	HP	NDC Ind	Surg Ind	AV	M1 (26)	M2 (TC)	Asst Surg	Co-Surg	Unit price	Max Qty	State Max	Surg	Child	Adult	Unit price	State Max
J3473	T	04	10/01/18	N	Y	N						0.358	300	107.40				0.35	104.50
J3475	T	04	10/01/18	N	Y	N						0.766	20	15.32				0.75	14.91
J3480	T	04	10/01/18	N	Y	N						0.15	20	3.00				0.15	2.92
J3485	T	04	10/01/18	N	Y	N						1.513	20	30.26				1.47	29.44
J3489	T	04	10/01/18	N	Y	N						12.448	5	62.24				12.11	60.56
J3490	T, U*	04		Y	Y	N													
J3530	T	04		Y		N													
J3590	T	04		Y	Y	N													
J7121	T	04	10/01/18	N	Y	N						1.95	3	5.85				1.90	5.69
J7131	T	04	10/01/18	N	Y	N						.0044	500	2.24				0.00	2.18
J7175	T	04	10/01/18	N	Y	N						6.00	9999	59,994.00				5.84	58,374.16
J7178	T	04	10/01/18	N	Y	N						1.10	9100	10,010.00				1.07	9,739.73
J7179	T	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	Y	N						8.228	5000	41,140.00				8.01	40,029.22
J7181	T	04	10/01/18	N	Y	N						10.24	4500	46,080.00				9.96	44,835.84
J7182	T	04	10/01/18	N	Y	N						1.34	6250	8,375.00				1.30	8,148.88
J7183	T	04	10/01/18	N	Y	N						1.009	7500	7,567.50				0.98	7,363.18
J7185	T	04	10/01/18	N	Y	N						1.222	6250	7,637.50				1.19	7,431.29
J7186	T	04	10/01/18	N	Y	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

a) 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):

	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	N400781320695mg250	J0696	10122018	2			
2	0252	N400409733701mg250	J0696 76	10122018	1			
3								

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.

	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.

b) 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.

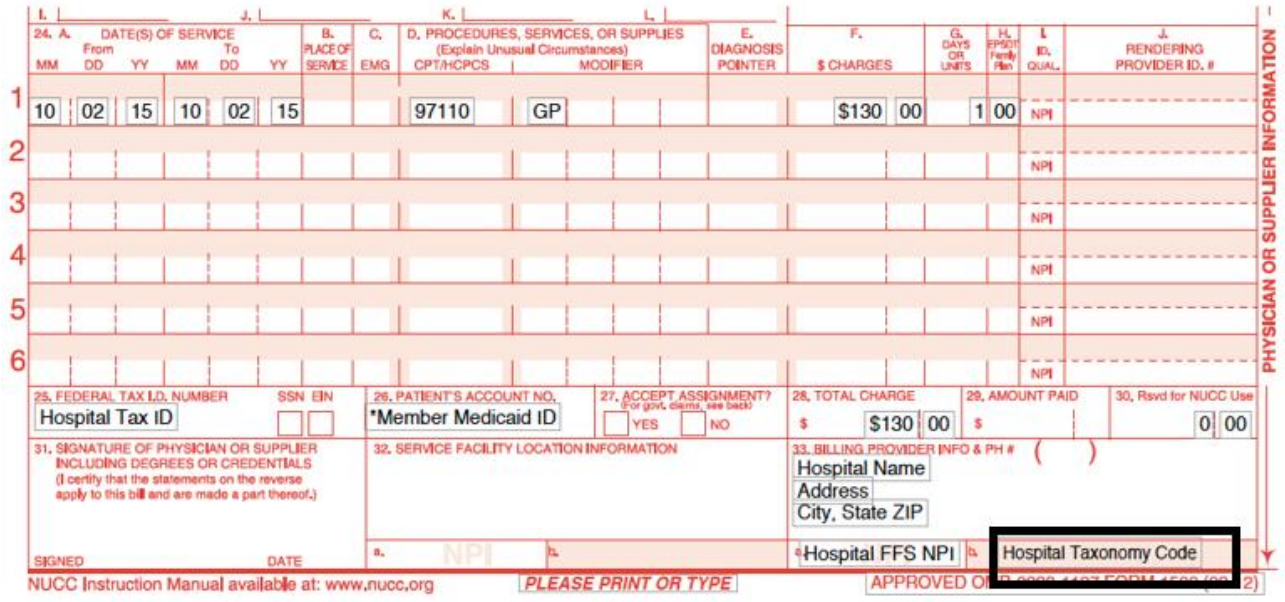
Payment for these services will be based on the same fee schedule and billable codes that apply to these services when they are provided in the non-hospital setting, except for physical therapy and occupational therapy which will pay at the APL rate.

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. See figure on next page.



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 Service Code	HFS Category of Service Description	Taxonomy
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 Billing with Different Taxonomies 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 here and are reimbursed based on the HFS 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

a) 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 the complete list by clicking here and scrolling to Appendix H-3.

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

b) 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.

c) Series Billing Dialysis Revenue Codes

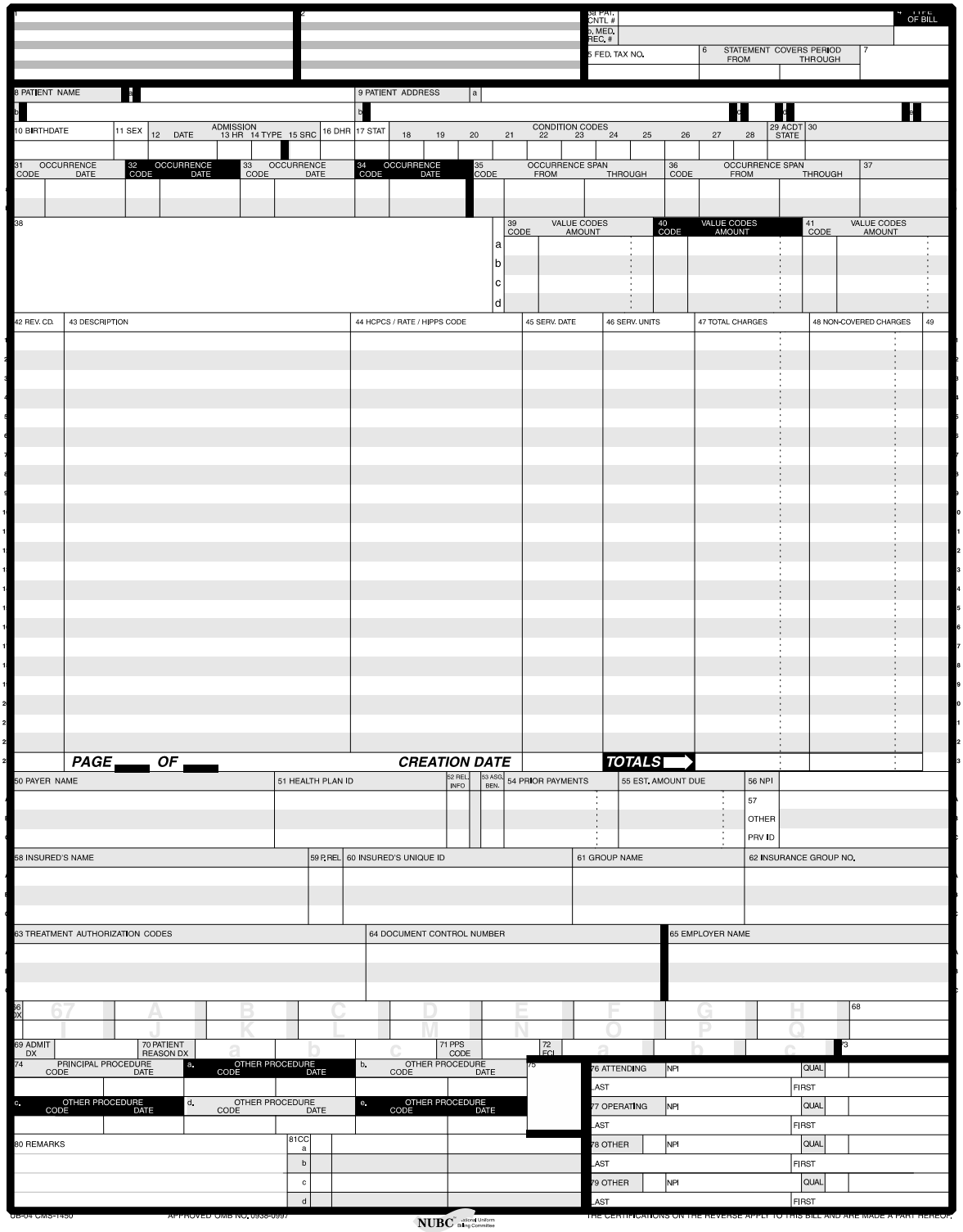
The following revenue codes are dialysis codes that can be billed as series billing. The specific dialysis codes are noted below from the list of series billable revenue codes that is located at the end of the outpatient section. These dialysis codes are still series billable after 7/1/2020. You can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

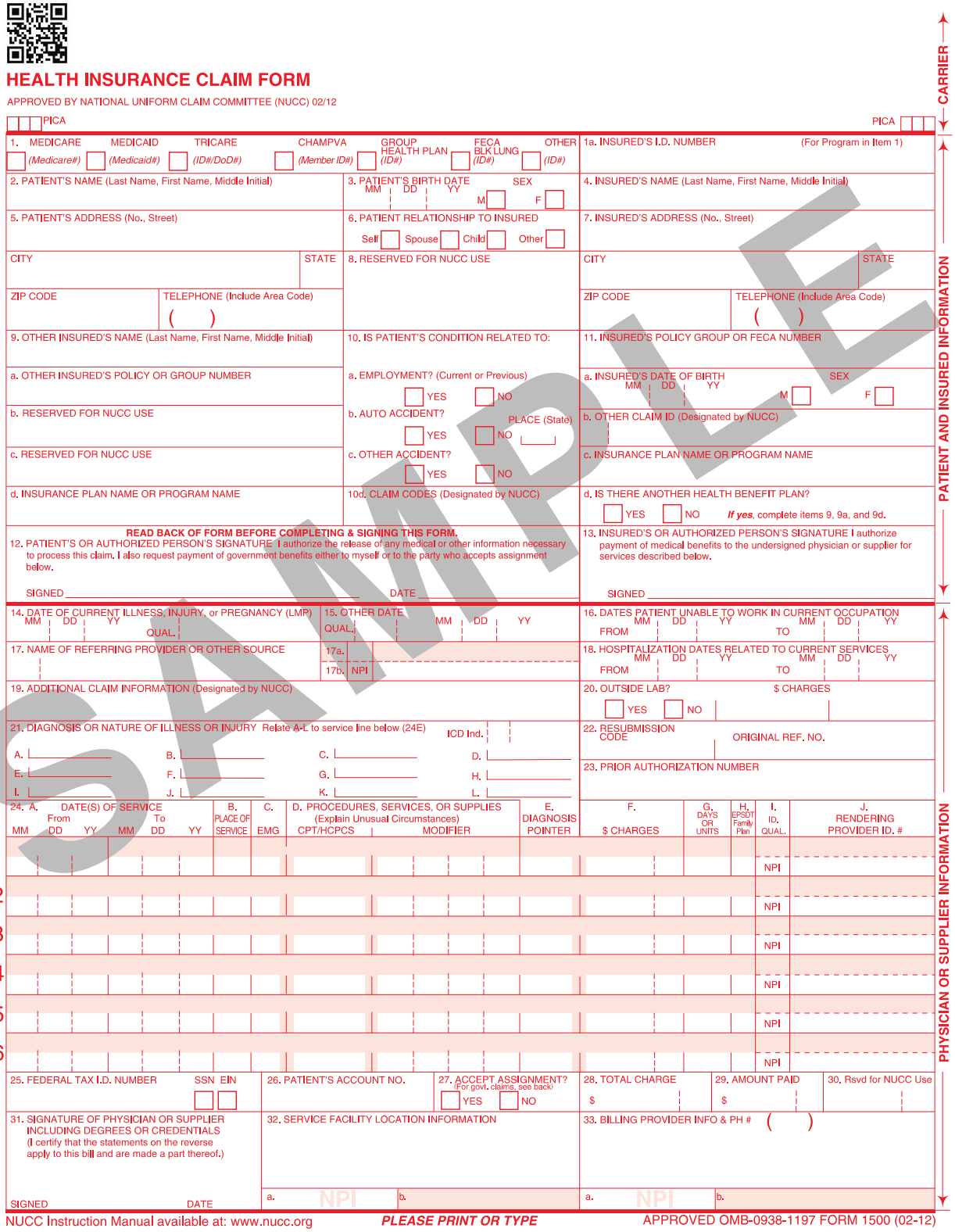
i. UB-04

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.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL 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. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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 here 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.

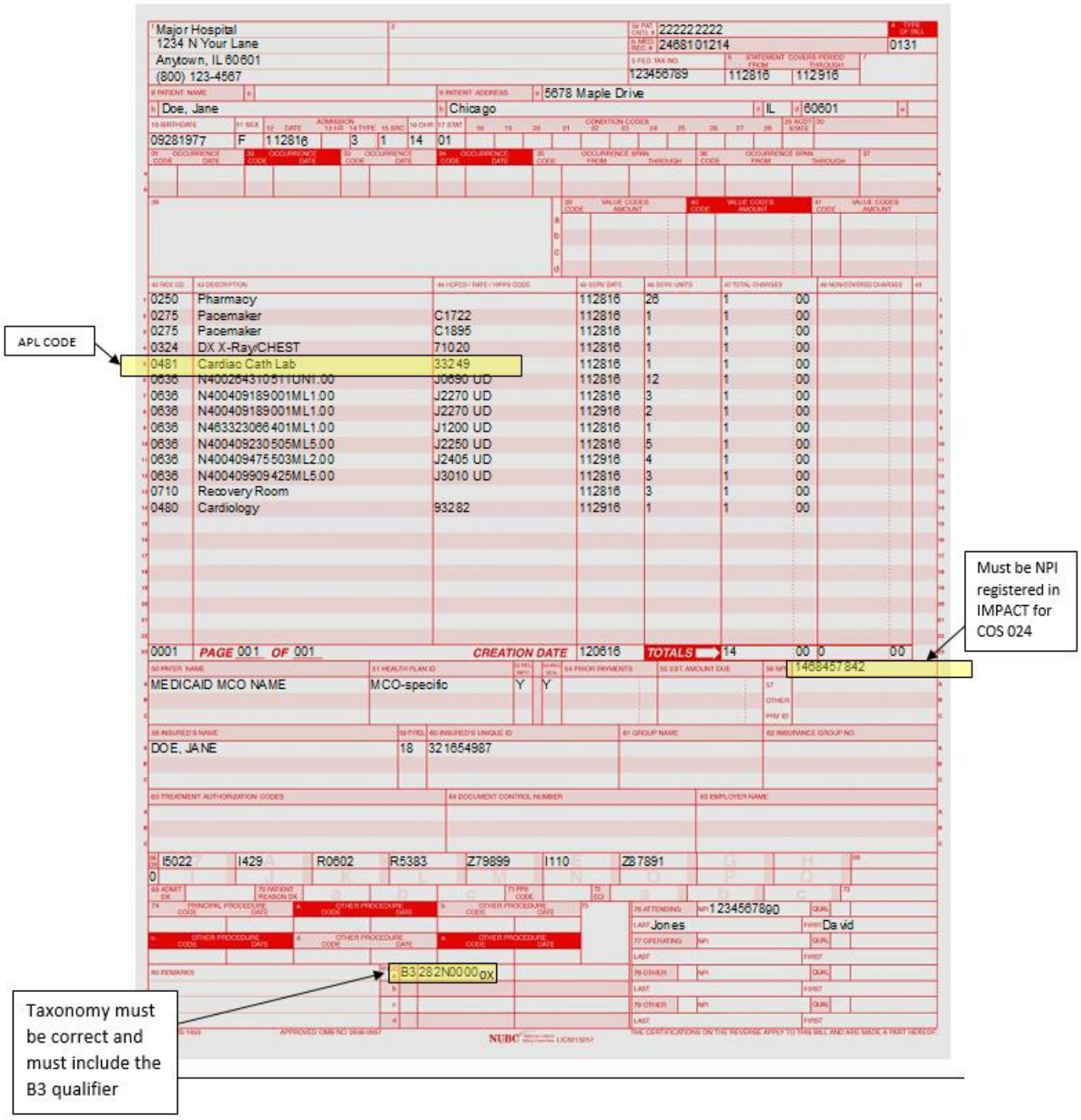
Billing Requirements for Scenario 1 (Non-Series Claims):

- 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
    - 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.

Scenario 1

Claim Example: Non-Series Claim (OP visit spanning two days/single episode of care) Claim prior to 7/1/2020



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.

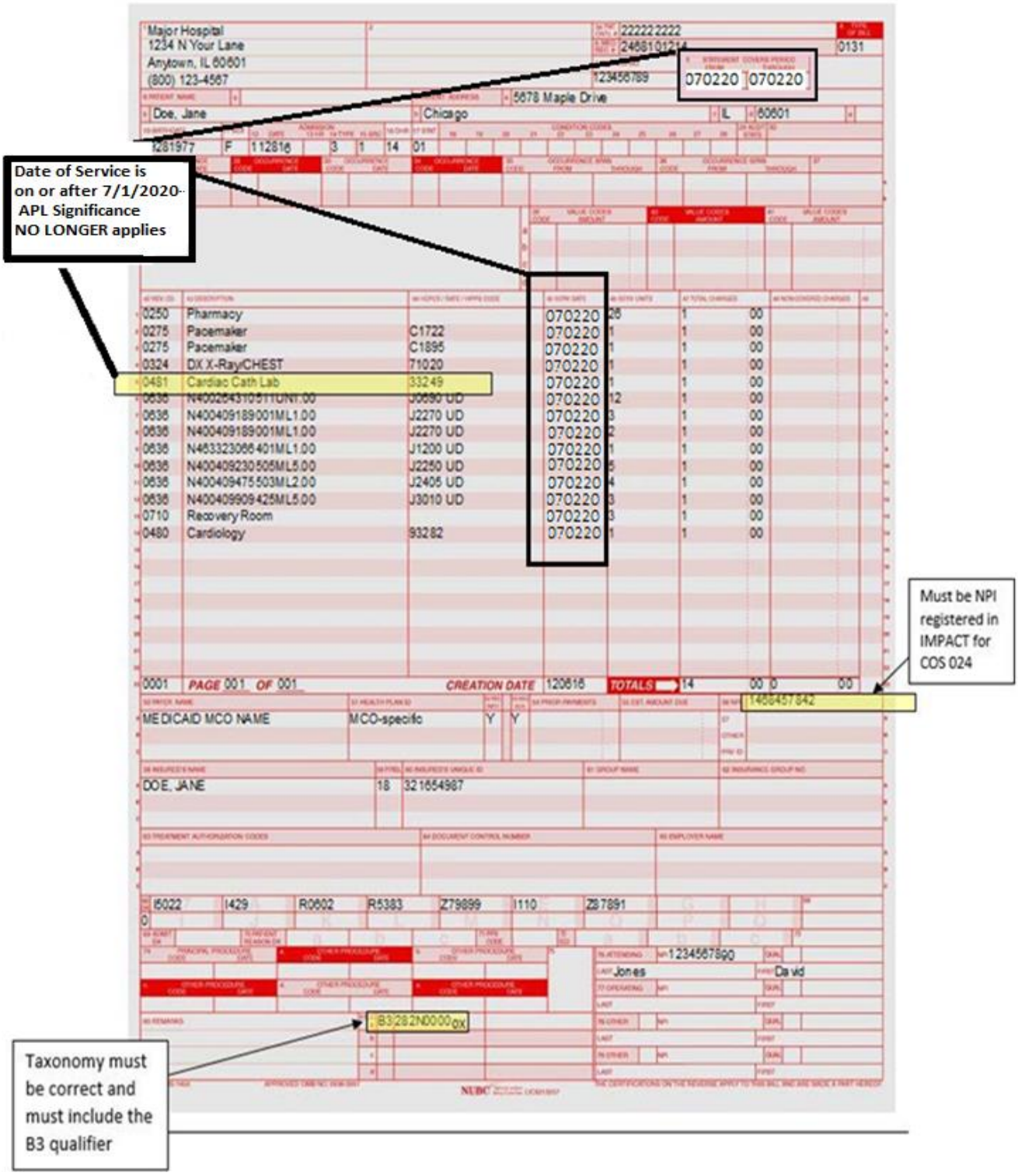
The outpatient services are all part of a single episode of care.

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
  - 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
  - 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.


Major Hospital
1234 N Your Lane
Anytown, IL 60601
(800) 123-4567
22222222
2468101214
0131
123456789
070220 070220
Doe, Jane
5678 Maple Drive
Chicago
IL
60601
1281977
F
112816
Date of Service is on or after 7/1/2020- APL Significance NO LONGER applies
0250 Pharmacy 070220 26 1 00
0275 Pacemaker C1722 070220 1 1 00
0275 Pacemaker C1895 070220 1 1 00
0324 DX X-Ray/CHEST 71020 070220 1 1 00
0481 Cardiac Cath Lab 33249 070220 1 1 00
0636 N400264310511UN1.00 J0690 UD 070220 12 1 00
0636 N400409189001ML1.00 J2270 UD 070220 3 1 00
0636 N400409189001ML1.00 J2270 UD 070220 2 1 00
0636 N463323066401ML1.00 J1200 UD 070220 1 1 00
0636 N400409230505ML5.00 J2250 UD 070220 5 1 00
0636 N400409475503ML2.00 J2405 UD 070220 4 1 00
0636 N400409909425ML5.00 J3010 UD 070220 3 1 00
0710 Recovery Room 070220 3 1 00
0480 Cardiology 93282 070220 1 1 00
0001 PAGE 001 OF 001 CREATION DATE 120616 TOTALS 14 00 0 00
Must be NPI registered in IMPACT for COS 024
1468457842
MEDICAID MCO NAME
MCO-specific
Y
Y
DOE, JANE
18
321654987
I5022 I429 R0602 R5383 Z79899 I110 Z87891
1234567890
Jones
David
Taxonomy must be correct and must include the B3 qualifier
B3282N0000qx
NUBC

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.

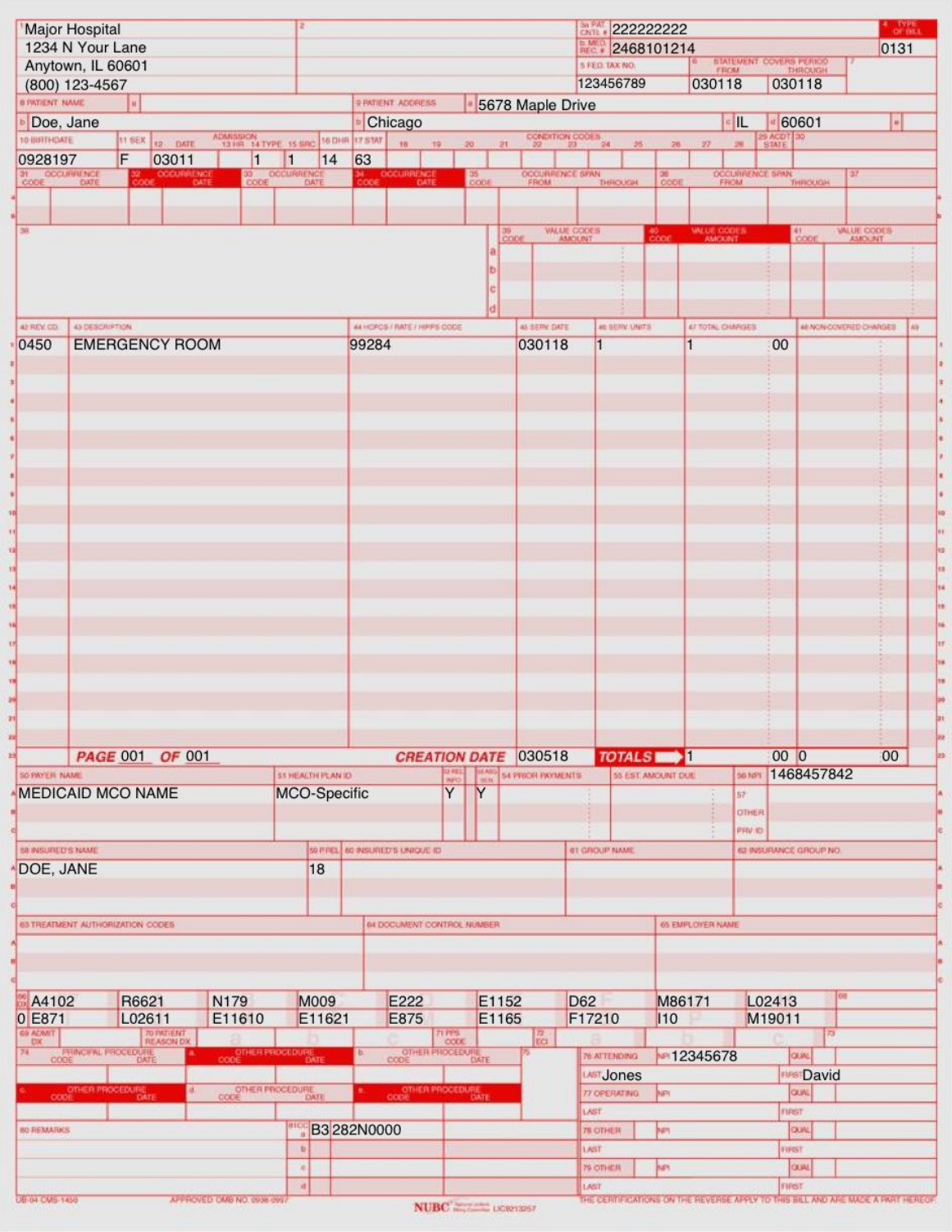
Emergency Room Services

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.

Scenario 2A

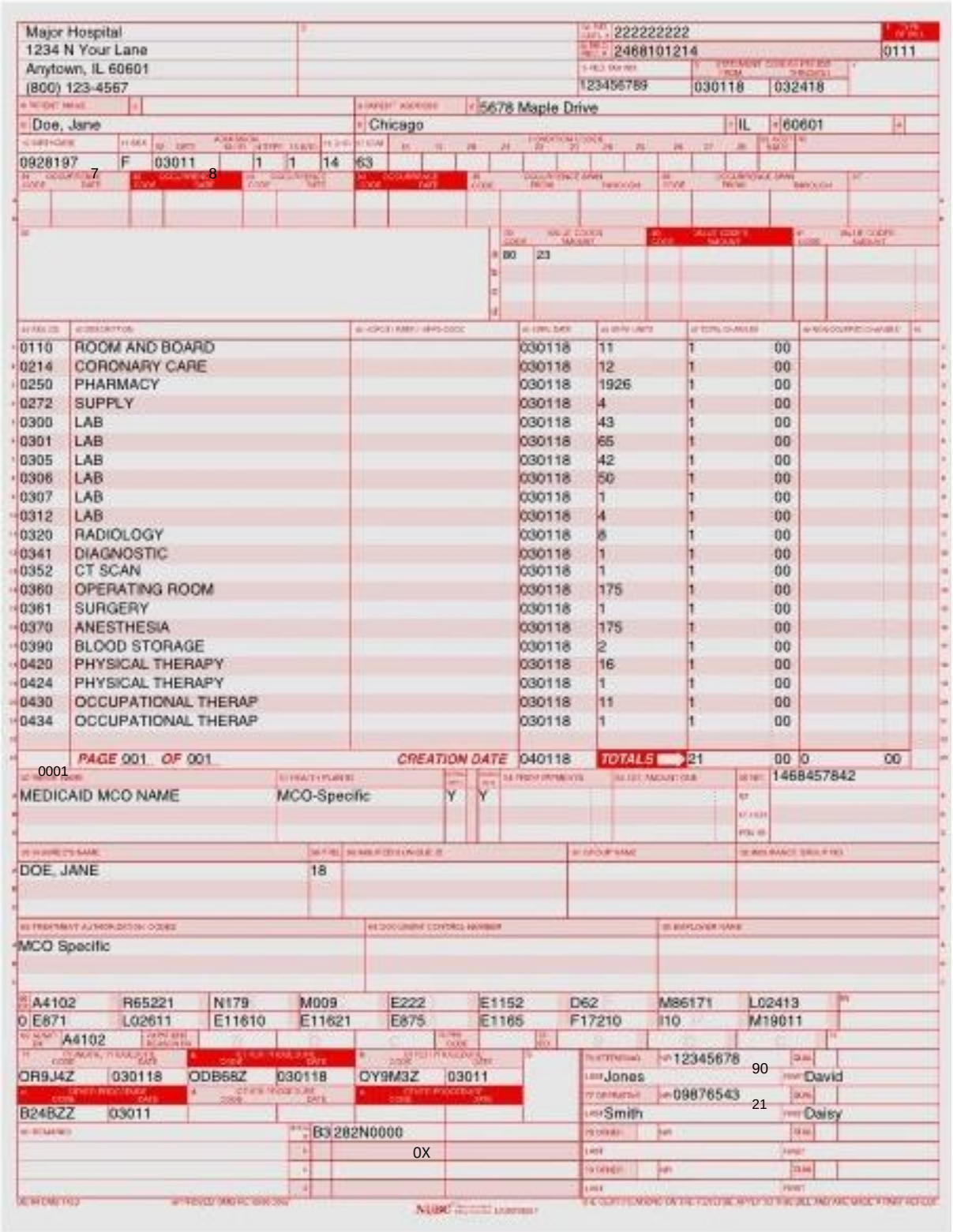
Claim Example 1: Emergency Room Services Only – (Bill Type = 0131)



| | | |

Scenario 2A

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.

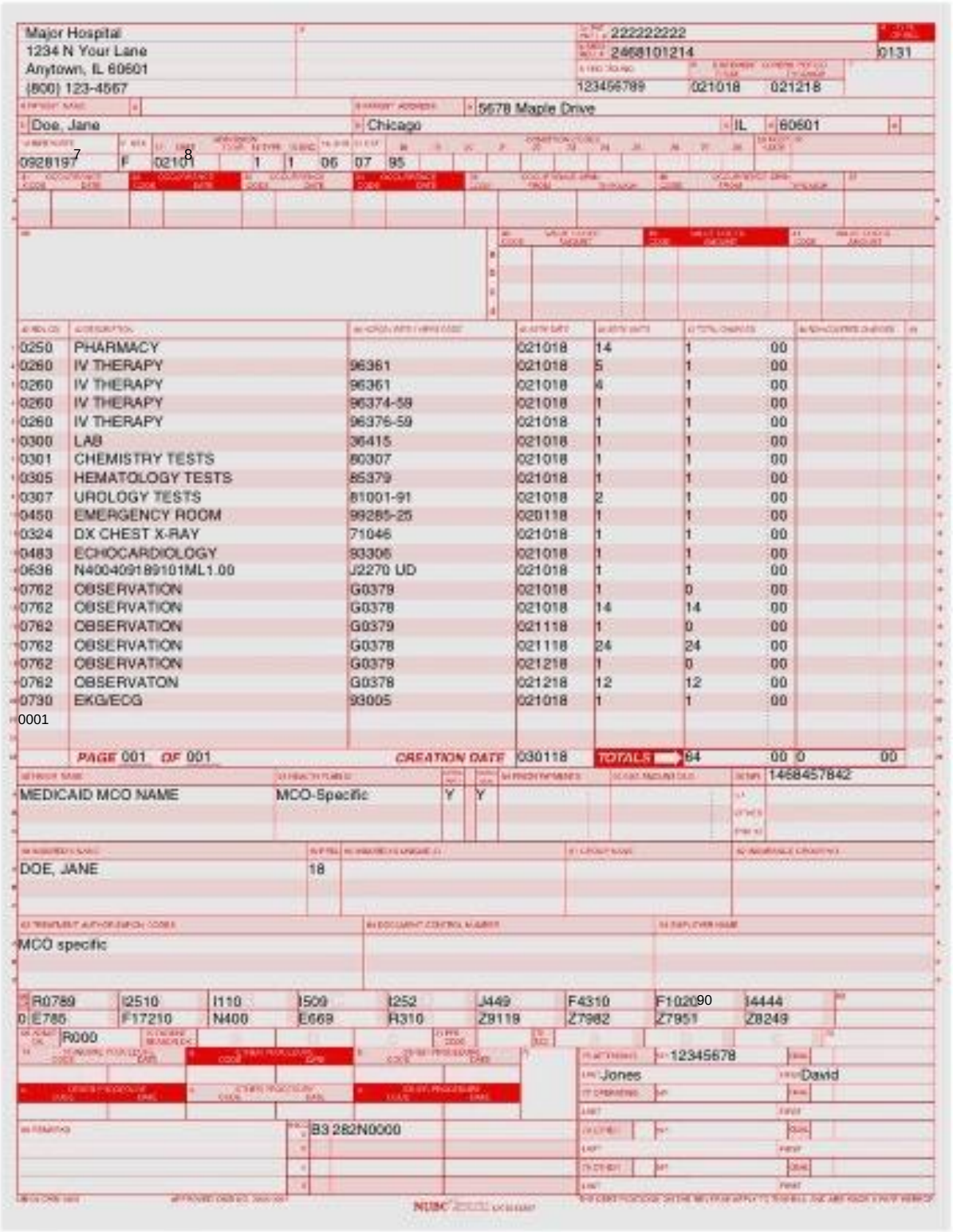
Claim 2:

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.

Scenario 2B:

Claim Example 1: ED and OBV services



Major Hospital
1234 N Your Lane
Anytown, IL 60601
(800) 123-4567

222222222
2468101214 0131
123456789 021018 021218

5678 Maple Drive
Doe, Jane | Chicago | IL | 60601

0928197 F 021018 1 1 06 07 95

0250	PHARMACY		021018	14	1	00	
0260	IV THERAPY	96361	021018	5	1	00	
0260	IV THERAPY	96361	021018	4	1	00	
0260	IV THERAPY	96374-59	021018	1	1	00	
0260	IV THERAPY	96376-59	021018	1	1	00	
0300	LAB	36415	021018	1	1	00	
0301	CHEMISTRY TESTS	80307	021018	1	1	00	
0305	HEMATOLOGY TESTS	85379	021018	1	1	00	
0307	UROLOGY TESTS	81001-91	021018	2	1	00	
0450	EMERGENCY ROOM	99285-25	020118	1	1	00	
0324	DX CHEST X-RAY	71046	021018	1	1	00	
0483	ECHOCARDIOLOGY	93306	021018	1	1	00	
0636	N4004091891O1ML1.00	J2270 UD	021018	1	1	00	
0762	OBSERVATION	G0379	021018	1	0	00	
0762	OBSERVATION	G0378	021018	14	14	00	
0762	OBSERVATION	G0379	021118	1	0	00	
0762	OBSERVATION	G0378	021118	24	24	00	
0762	OBSERVATION	G0379	021218	1	0	00	
0762	OBSERVATON	G0378	021218	12	12	00	
0730	EKG/ECG	93005	021018	1	1	00	
0001							
	PAGE 001 OF 001		CREATION DATE 030118	TOTALS	84	00 0	00

MEDICAID MCO NAME | MCO-Specific | Y | Y | 1468457842

DOE, JANE | 18

MCO specific

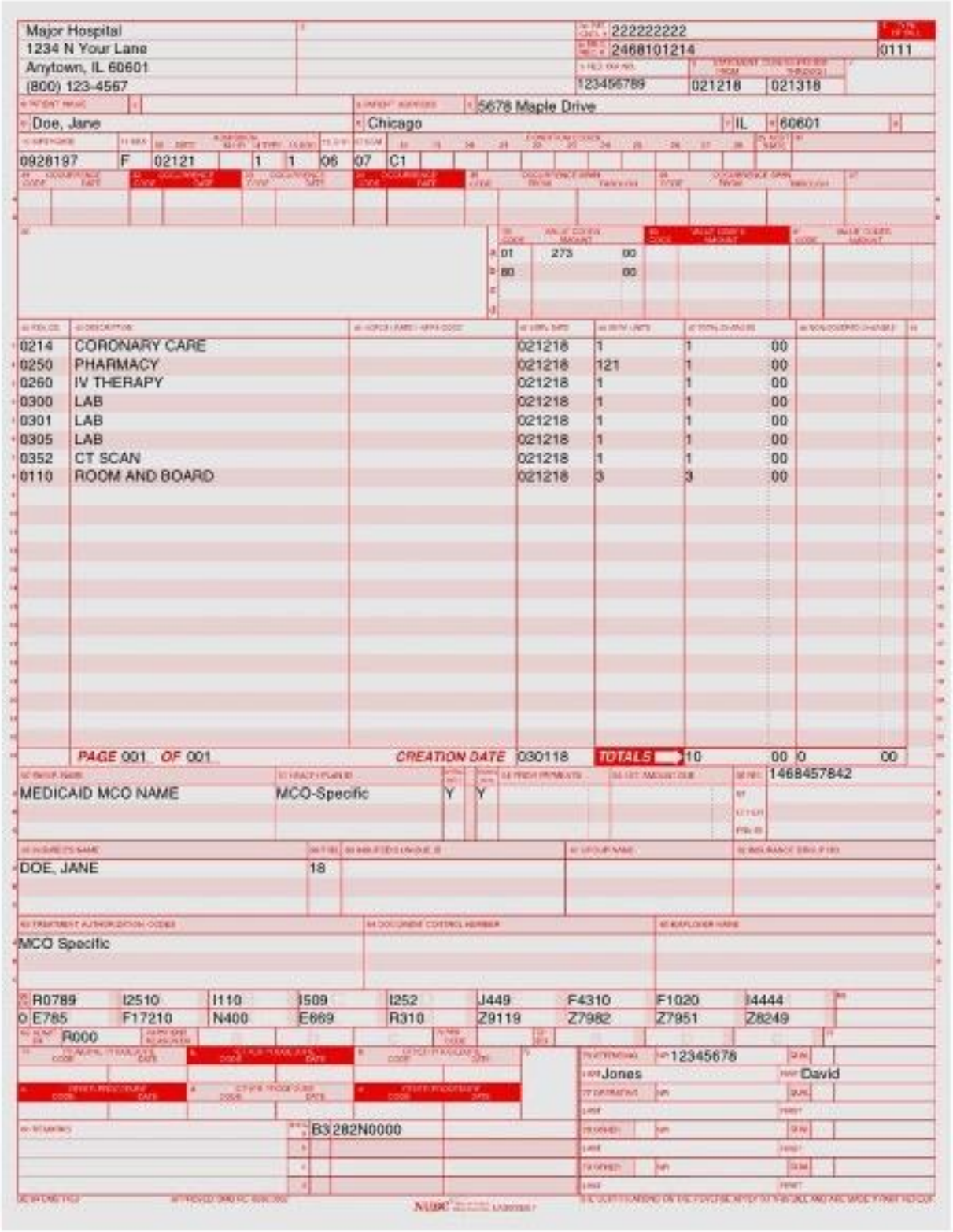
R0789 I2510 I110 I509 I252 J449 F4310 F10209O I4444
E785 F17210 N400 E669 H310 Z9119 Z7982 Z7951 Z8249
R000

12345678
Jones | David

B3 282N0000

Scenario 2B:

Claim Example 2: Inpatient Admission on Subsequent Day of Service



Major Hospital
1234 N Your Lane
Anytown, IL 60601
(800) 123-4567

222222222
2468101214
0111
123456789 021218 021318

Doe, Jane | 5678 Maple Drive | Chicago | IL | 60601

0928197 F 02121 1 1 06 07 C1

01 273 00
80 00

0214	CORONARY CARE	021218	1	1	00	
0250	PHARMACY	021218	121	1	00	
0260	IV THERAPY	021218	1	1	00	
0300	LAB	021218	1	1	00	
0301	LAB	021218	1	1	00	
0305	LAB	021218	1	1	00	
0352	CT SCAN	021218	1	1	00	
0110	ROOM AND BOARD	021218	3	3	00	
	PAGE 001 OF 001	CREATION DATE 030118	TOTALS	10	00	0 00

MEDICAID MCO NAME | MCO-Specific | Y | Y | 1468457842

DOE, JANE | 18

MCO Specific

R0789 I2510 I110 I509 I252 J449 F4310 F1020 J4444
E785 F17210 N400 E669 R310 Z9119 Z7982 Z7951 Z8249
R000

12345678
Jones | David

B3282N0000

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. ***Please ensure that NDCs used are validated against MediSpan to ensure a clean claim submission.*** 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:

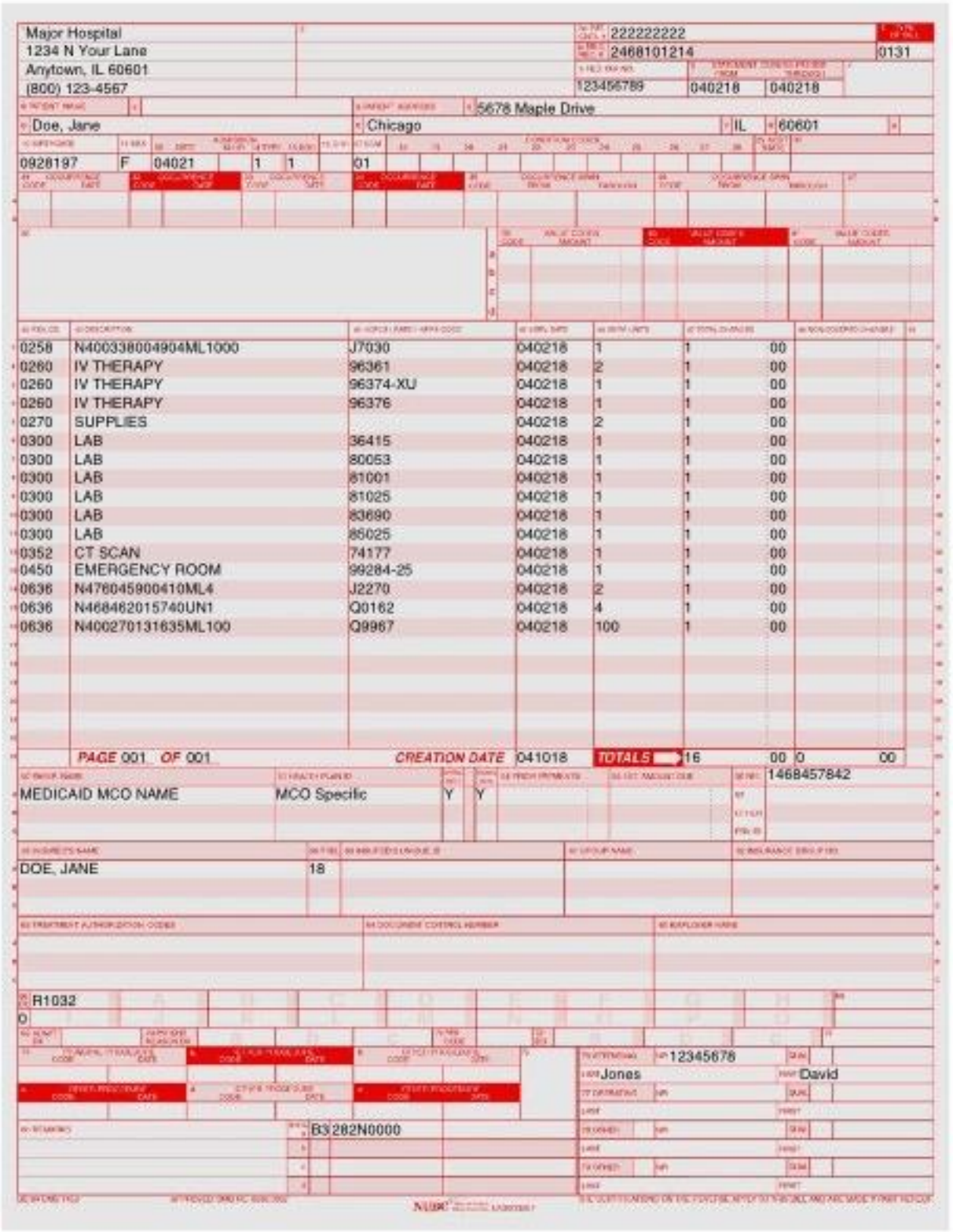
NDC on Label	Configuration on Label	NDC in Required 5-4-2 Format
05678-123-01	5-3-2	05678-0123-01
5678-0123-01	4-4-2	05678-0123-01
05678-0123-1	5-4-1	05678-0123-01

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.

Scenario 3:

Claim Example 1: NDC Reporting



Major Hospital
1234 N Your Lane
Anytown, IL 60601
(800) 123-4567

222222222
2468101214
0131
123456789 040218 040218

Doe, Jane | 5678 Maple Drive | Chicago | IL | 60601

0928197 F 04021 1 1 01

0258	N400338004904ML1000	J7030	040218	1	1	00
0260	IV THERAPY	96361	040218	2	1	00
0260	IV THERAPY	96374-XU	040218	1	1	00
0260	IV THERAPY	96376	040218	1	1	00
0270	SUPPLIES		040218	2	1	00
0300	LAB	36415	040218	1	1	00
0300	LAB	80053	040218	1	1	00
0300	LAB	81001	040218	1	1	00
0300	LAB	81025	040218	1	1	00
0300	LAB	83690	040218	1	1	00
0300	LAB	85025	040218	1	1	00
0352	CT SCAN	74177	040218	1	1	00
0450	EMERGENCY ROOM	99284-25	040218	1	1	00
0636	N476045900410ML4	J2270	040218	2	1	00
0636	N468462015740UN1	Q0162	040218	4	1	00
0636	N400270131635ML100	Q9967	040218	100	1	00

PAGE 001 OF 001 CREATION DATE 041018 TOTALS 16 00 0 00

MEDICAID MCO NAME | MCO Specific | Y | Y | 1468457842

DOE, JANE | 18

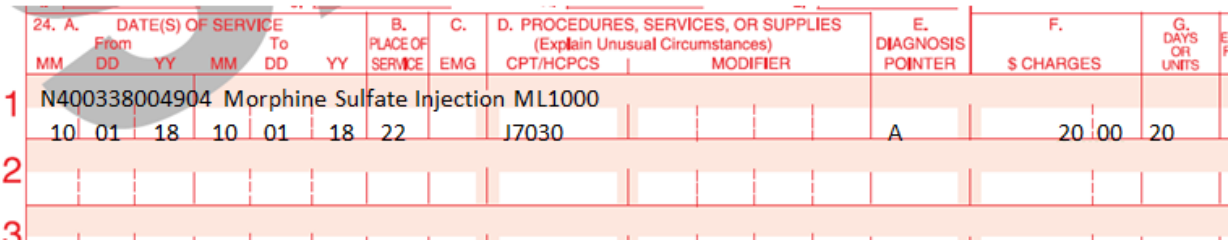
R1032
0

12345678
Jones | David

B3282N0000

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) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1 N400338004904 Morphine Sulfate Injection ML1000												
10	01	18	10	01	18	22		J7030		A	20 00	20
2												
3												

Scenario 4: Partial Hospitalization Services

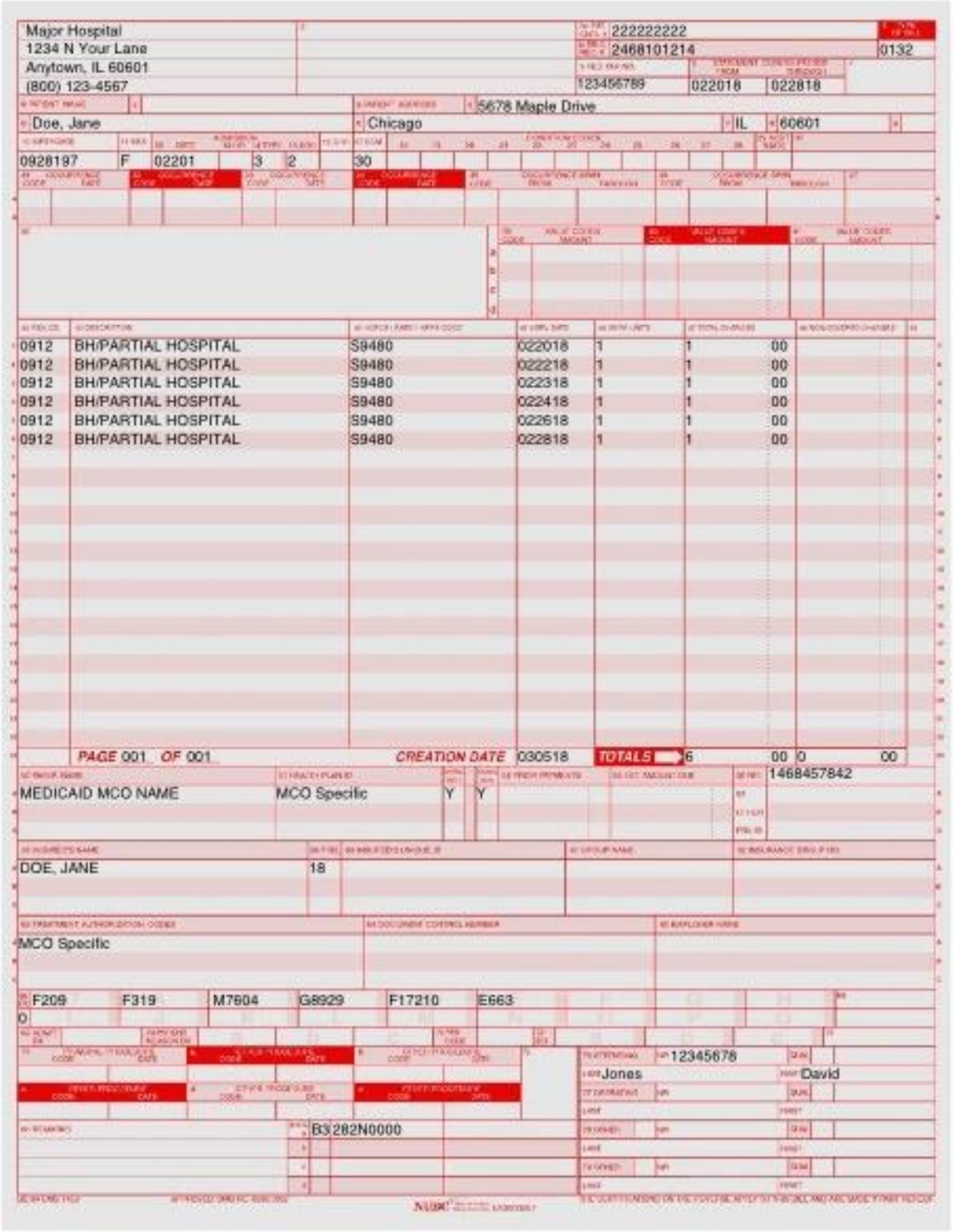
In this scenario, a patient presents for outpatient partial hospitalization services. There is no APL procedure code present in this situation and the services are billed on a UB-04 as Bill Type 132.

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.

Scenario 4:

Claim Example 1: Partial Hospitalization Services



Major Hospital
1234 N Your Lane
Anytown, IL 60601
(800) 123-4567

222222222
2468101214 0132
123456789 022018 022818

Doe, Jane | 5678 Maple Drive | Chicago | IL | 60601

0928197 F 02201 3 2 30

0912	BH/PARTIAL HOSPITAL	S9480	022018	1	1	00	
0912	BH/PARTIAL HOSPITAL	S9480	022218	1	1	00	
0912	BH/PARTIAL HOSPITAL	S9480	022318	1	1	00	
0912	BH/PARTIAL HOSPITAL	S9480	022418	1	1	00	
0912	BH/PARTIAL HOSPITAL	S9480	022618	1	1	00	
0912	BH/PARTIAL HOSPITAL	S9480	022818	1	1	00	
	PAGE 001 OF 001	CREATION DATE	030518	TOTALS	6	00	0 00

MEDICAID MCO NAME | MCO Specific | Y | Y | 1468457842

DOE, JANE | 18

MCO Specific

F209 F319 M7604 G8929 F17210 E663

0

12345678
Jones David

B3282N0000

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.

III. 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.

i. NPIs

Psychiatric Hospitals are required to register their NPIs as a Provider Type 31 - Psychiatric Hospitals.

ii. 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 an 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.

iii. 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	283Q00000X Psychiatric Hospital or 273R00000X Psychiatric Unit
31	27	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	
31	28	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	

C. Billing Requirements

i. Outpatient Requirements

- 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

- 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.

IV. 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.

i. NPIs

Rehabilitation Hospitals are required to register their NPIs as a Provider Type 32 - Rehabilitation Hospitals.

ii. 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 an 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.

iii. 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 283XC2000X Rehabilitation Hospital (Children) or 283X00000X Rehabilitation Hospital
32	29	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	

C. Billing Requirements

iv. Outpatient Requirements

- 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.

v. 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.

V. 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.

i. NPIs

LTAC Hospitals are required to register their NPIs as a Provider Type 30- General Acute Care.

ii. 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 an 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.

iii. 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.	284300000X (Specialty Hospital)
30	024	131, 132, 133, 134, 135,141, 142, 143, 144, 145, 851, 852, 853, 854, 855	

C. Billing Requirements

i. Outpatient Requirements

- 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

- Providers should submit claims following the Interim Billing Guidelines outlined in the Inpatient Hospital Section.
- 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.

VI. 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 ***must*** 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
- 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
- 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.

- 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.

i. 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 = 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 *must* match. If bill type ends in 2, statement from date and admit date *must* match. If bill type ends in 3 or 4, statement from date and admit date *cannot* 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
39-41	Value Codes	Required	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 **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.
42	Revenue Codes	Required	Rev code 0110-0160 = General room & board except (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 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 as well. 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)

VII. 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 term 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
    - 2/6/19-2/28/19
- Example 3: with a discharge date of 2/20/19
    - 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
39-41	Value Codes	Required	80 = must equal "covered days" 81 = any non-covered days and all LOA days (whether payable or not) **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** 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
42	Revenue Codes	Required	Rev code 0240: All-inclusive Ancillary General Services Rev code 0182: Leave of Absence Patient Convenience Rev code 0183: Leave of Absence Therapeutic Leave Rev code 0185: Hospitalization Leave of absence revenue codes are reimbursed as follows: • Days 1-30 reimbursable each SFY (July – June) • Days >30 not reimbursable each SFY (July – June)

Form Locator Field	Explanation	Completion Needed	Comments
			SLF's receive a total of 30 payable LOA days per fiscal year, regardless of type. Any LOA days exceeding 30 should be priced at $0.00. 0185 days are included in the payable LOA count.
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 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

VIII. 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 an 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. Use revenue code 0130 for rooms with 3 and/or 4 beds.

  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)
  - 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 Field	Explanation	Completion Needed	Comments
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 *must* match If bill type ends in 2, statement from date and admit date *must* match If bill type ends in 3 or 4, statement from date and admit date *cannot* match and must be the original admission date

<table>
<tr><th>Form Locator Field</th><th>Explanation</th><th>Completion Needed</th><th>Comments</th></tr>
<tr><td>17</td><td>Patient Discharge Status</td><td>Required</td><td>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</td></tr>
<tr><td>31-34</td><td>Occurrence Code</td><td>Conditional</td><td>55 when billing patient discharge status = 20</td></tr>
<tr><td>35-36</td><td>Occurrence Span Code</td><td>Conditional</td><td>74 only when billing a LOA
Must have a LOA revenue code on the claim 018X and value code 81.
Include dates of the LOA</td></tr>
<tr><td>39-41</td><td>Value Codes</td><td>Required</td><td>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</td></tr>
<tr><td>42</td><td>Revenue Codes</td><td>Required</td><td>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</td></tr>
<tr><td>43</td><td>Revenue Code Description</td><td>Required</td><td></td></tr>
<tr><td>44</td><td>HCPCS/Accommodation Rates</td><td>Optional</td><td></td></tr>
<tr><td>45</td><td>Service Date</td><td>Required</td><td>It is permitted to bill for a span such as 10/1-10/31/24 if days are consecutive.
When there is a LOA, service dates and rev codes must be grouped together when consecutive.
Effective with DOS beginning 9/1/25: If the service dates are not consecutive, providers need to split the dates for that revenue code on separate service lines rather than combining the days on one line.
Example: Member has 2 LOA days (Rev Code 0183) in the middle of the month, with the remaining days of the month billed with Rev Code 0120.
<table>
<tr><th colspan="3">Incorrect Billing</th></tr>
<tr><th>Line Level Revenue Codes</th><th>Line Level Units</th><th>Line Level Date Span In RD8 Format</th></tr>
<tr><td>0120</td><td>11</td><td>20241001-20241031</td></tr>
<tr><td>0183</td><td>2</td><td>20241001-20241031</td></tr>
<tr><td>0120</td><td>18</td><td>20241001-20241031</td></tr>
<tr><th colspan="3">Correct Billing</th></tr>
<tr><td>0120</td><td>11</td><td>20241001-20241011</td></tr>
<tr><td>0183</td><td>2</td><td>20241012-20241013</td></tr>
<tr><td>0120</td><td>18</td><td>20241014-20241031</td></tr>
</table></td></tr>
</table>

Form Locator Field	Explanation	Completion Needed	Comments
			837I/EDI INCORRECT BILLING FORMAT: HI*ABK:F259:::::::N HI*ABJ:F259 **HI*BI:74:RD8:20241012-20241013** HI*BE: 80:29*BE:81:::2*BE:23:::903 HI*BG:C1 HCP*13*4129.93 NM1*71*1*AKIRA*ALAN****XX*1710470257 PRV*AT*PXC*2084P0800X LX*1 SV2*0120**3300*DA*11 **DTP*472*RD8*20241001-20241031 This rev code is for 11 days.** The specific date range must be billed LX*2 SV2*0183**214*DA*2**214 DTP*472*RD8*20241001-20241031 **This rev code is for 2 days, and the occurrence span 74 shows the LOA days as 10/12/24-10/13/24, so those days should have been listed here instead of 10/01/24 – 10/31/24** LX*3 SV2*0120**5400*DA*18 DTP*472*RD8*20241001-20241031 **This rev code is for 18 days. The specific date range must be billed** **837I/EDI CORRECT BILLING FORMAT:** HI*ABK:F259:::::::N HI*ABJ:F259 **HI*BI:74:RD8:20241012-20241013** HI*BE: 80:29*BE:81:::2*BE:23:::903 HI*BG:C1 HCP*13*4129.93 NM1*71*1*AKIRA*ALAN****XX*1710470257 PRV*AT*PXC*2084P0800X LX*1 SV2*0120**3300*DA*11 **DTP*472*RD8*20241001-20241011** LX*2 SV2*0183**214*DA*2**214 **DTP*472*RD8*20241012-20241013** LX*3 SV2*0120**5400*DA*18 **DTP*472*RD8*20241014-20241031**
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

Form Locator Field	Explanation	Completion Needed	Comments
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

IX. 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 with the taxonomy code 261QA1903X.

D. Billing Requirements

i. Covered 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.

a) 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.

b) 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 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.

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.

c) 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

i. 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 **Form 1977 Acknowledgement of Receipt of Hysterectomy Information** indicates that the patient was informed that the hysterectomy will render her permanently incapable of reproducing. **Completion of this form is required regardless of age.** 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.

ii. 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 must be completed and attached to the UB-04 when submitting to the MCO for the claim to be processed.

iii. 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 Prior Authorization section in this manual for information by MCO on prior authorization requirements and request process.

X. 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 an 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	**Effective with DOS beginning 1/1/25:** One of the following procedure codes must be identified on the claim: 99221; 99222; 99223; 99234; 99235; 99236 *minimum unit = 1 hour **For DOS prior to 7/1/22 to 12/31/24:** 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.

XI. 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.

i. 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
    - Revenue code 0656: General Inpatient Care
    - Revenue code 0657: Physician Services
    - Revenue code 0658: LTC Room & Board
    - 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 website.

H. 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 *must* match If bill type ends in 2, statement begin date and admit date *must* match If bill type ends in 3 or 4, statement begin date and admit date *cannot* match

Form Locator Field	Explanation	Completion Needed	Comments
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
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/Accommodation 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).**

Form Locator Field	Explanation	Completion Needed	Comments
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 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 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	Conditional	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

XII. 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

i. PIs

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 an 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.

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

* HFS Provider Type 57 (Home Health Agency) is not a billable provider type to the MCOs. All PT 57 providers are directed to reach out to *The Division of Specialized Care for Children* (DSCC) for assistance in filing claims to this agency.

Revenue Code	Definition of Services Performed	HCPCS	Modifier
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	
04	Type of Bill	Required	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 • 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
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	

Form Locator Field	Explanation	Completion Needed	Comments
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

Part C: Professional Billing (837P, 837D, CMS-1500 or NDCDP Claim Types)

I. 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 Registration and Billing Requirements

i. Provider Type, Specialty, Subspecialty, and Categories of Service

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 with the appropriate specialty, subspecialty/subspecialties, and categories of service (COS).

IMPACT Provider Type	IMPACT Specialty	IMPACT Subspecialty	Legacy Provider Type	Legacy COS
Clinic	Federally Qualified Health Center (FQHC)	School Based School Linked Behavioral Health/Social Work Behavioral Health/Psychologist Services Behavioral Health/Licensed Marriage & Family Therapist (LMFT) Services Behavioral Health/Licensed Clinical Professional Counseling Dental Services Visiting Nurse Services No Subspecialty	040	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)*
Clinic	Rural Health Center (RHC)	Behavioral Health/Social Work Behavioral Health/Psychologist Services Behavioral Health/Licensed Marriage & Family Therapist (LMFT) Services Behavioral Health/Licensed Clinical Professional Counseling Dental Services Visiting Nurse Services	048	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

IMPACT Provider Type	IMPACT Specialty	IMPACT Subspecialty	Legacy Provider Type	Legacy COS
		No Subspecialty		088 Licensed Clinical Professional Counselor or Licensed Marriage & Family Therapist 102 Fluoride Varnish for Children under 36 mos. 104 Long-Acting Reversible Contraceptives (LARCs)*
Clinic	Encounter Rate Clinic (ERC)	No Subspecialty	043	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.*

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. Taxonomy Codes

The acceptable taxonomy codes for Encounter Clinics are outlined in the table below.

Provider Type	Taxonomy Code
Federally Qualified Health Center (FQHC)	261QF0400X
Rural Health Center (RHC)	261QR1300X
Encounter Rate Clinic (ERC)	261QP2300X

iii. Place of Service

The acceptable place of service codes for Encounter Clinics (billing encounter rate codes) are outlined below.

Place of Service Code	Description
02	Telehealth provided other than in Patient's Home (distant site only)
03	School based clinics with SB or SL specialty on their provider file.
10	Telehealth rendered to patient located in their home (distant site only)
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit/Clinic
27	Outreach Site/Street (effective 10/1/23)
31	Skilled Nursing Facility
32	Nursing Facility

Place of Service Code	Description
33	Custodial Care Facility
49	Independent Clinic
50	FQHC
72	Rural Health Clinic

If providers are billing FFS (i.e. not an encounter rate code), another POS may be applicable.

Click here to view the POS, COS, PROC document.

C. 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 encounter 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:
  - 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.

a) 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 always be available at the originating site.

b) 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 above.
- 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 aged 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.

D. 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

E. 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 rate CPT code of T1015, T1040, or S5190 for medical/behavioral health services or D0999 for dental services listed in the first service line of the claim, along with the clinic's assigned encounter rate. The CPT codes for the services rendered must then be listed in the remaining service lines 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.

For Maternity services, FQHC, RHC, and ERC providers should follow the coding guidance for individual maternity services as outlined in the Family Planning, Maternity and Reproductive Care section of the Professional Services chapter of this manual.

a) Procedure Code S5190

- Procedure code S5190 must be billed when a wellness assessment is performed by a non-physician.
- 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.

b) Behavioral Health Encounters

Encounters should be submitted with the encounter CPT code of T1040 with the appropriate modifier outlined below in the first service section along with the clinic's assigned behavioral health encounter rate. 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 a 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 health encounter on the same day of service.

Specific modifiers must be appended to the first service line based on the rendering provider's registered IMPACT specialty and Category of Service:

Specialty	Category of Service	CPT & Modifier Claims prior to 2/1/2023	CPT & Modifier Claims 2/1/2023 forward
Licensed Clinical Social Worker (LCSW)	058	T1015 AJ modifier	T1040 AJ modifier
Licensed Clinical Psychologist	059	T1015 AH modifier	T1040 AH modifier
Licensed Clinical Professional Counselor (LCPC)	088	T1015 HO modifier	T1040 HO modifier
Licensed Marriage and Family Therapist (LMFT)	088	T1015 HO modifier	T1040 HO modifier

c) 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.
- When billing D0999, claims should be submitted to the MCO's dental vendor, not the MCO directly (see Dental Section for further details).

d) 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 aged 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 tray 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.

e) Telehealth Encounters

Telehealth Encounters when the clinic is the Originating Site should be submitted with the encounter CPT code (T1015 or T1040 as applicable) 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 or the patient is in their home), then the clinic billing the distant site service must use POS 02 or POS 10 respectively.

Telehealth billing examples:

1. Originating Site: Encounter Clinic

Bill the encounter HCPCS code T1015 (or T1040 as appropriate) 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.

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.

2. Originating Site: Physician/APN/Podiatrist's Office

Originating Provider will bill HCPCS code Q3014

Distant Site: Encounter Clinic

Bill the Encounter HCPCS code T1015 (or T1040 as appropriate) and any appropriate detail codes with GT (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.

3. 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

- **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.

iv. Submission Guidelines and Sample 1500 Forms

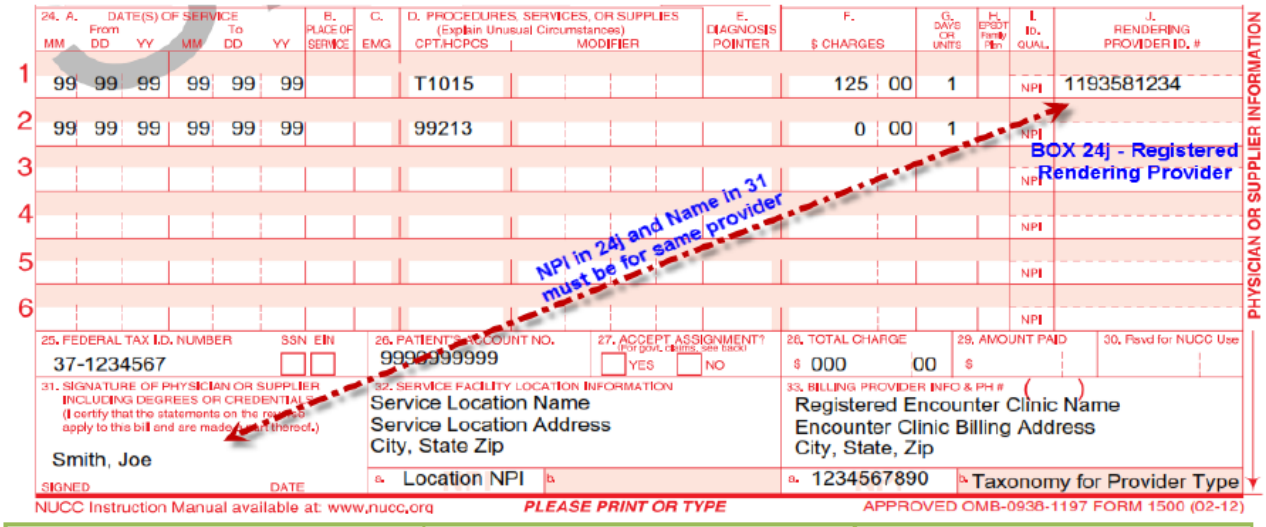
Encounter Rate Submission Guidelines

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	Signature of Physician
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, and NPI. Per X12 EDI guidance NO P.O. Boxes or LOCK box permitted in this loop (2010AA)
	2000A	PRV03	Appropriate taxonomy for the registered provider specialty type in IMPACT: • FQHC Providers: 261QF0400X • ERC Providers: 261QP2300X • RHC Providers: 261QR1300X
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),BCCHP, CountyCare, and Meridian 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:

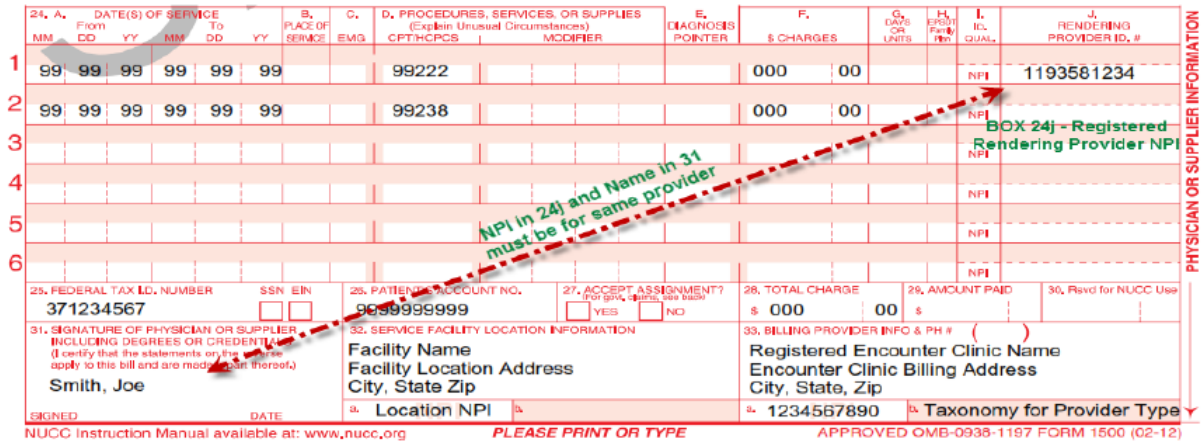


Box 31	Box 32	Box 33
Registered rendering provider name	Approved encounter location when billing encounter code Office (POS11), Home (12), School (03), Nursing Home (POS 31, 32), Encounter Clinic (50, 71, 72)	Registered encounter clinic name, billing address as listed on the W-9, taxonomy for provider type, and the Encounter Group NPI

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
Box 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:



Box 31	Box 32	Box 33
Registered rendering provider name	Physical service location (POS 21) inpatient, (POS 22) outpatient	Registered encounter clinic name, billing address as listed on the W-9, taxonomy for provider type, and the Encounter Group NPI or FFS Group NPI

II. 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

i. 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 an MCO, it is critical that the provider's HFS IMPACT record is registered under the correct COS or the claim will deny.

ii. 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
    - 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

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. Please note that the link also includes a key to the fee schedule notes indicators.

i. 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 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.

ii. 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.

iii. Vaccinations

For detailed information on how to appropriately bill for vaccinations, refer to the SBHLC fee schedule key.

III. 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** 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.

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**
HOTV	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

** CountyCare DOES 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.*

Procedure Codes for Approved Risk Assessment Tools

NOTE: Effective with dates of service beginning April 1, 2023, one of the following G codes must be used for any depression screenings instead of 96127:

G8431: Screening for depression is documented as positive and a follow-up plan is documented.
G8510: Screening for depression is documented as negative and a follow-up plan is not documented.

Procedure Code	Recommended CPT Code prior to 4/1/2023	Recommended CPT Code effective 4/1/2023 (see note above)
Risk Assessment		
Problem-Oriented Screening Instrument for Teenagers (POSIT)	96127	G8431 or G8510
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Tool	96127	G8431 or G8510
Child and Adolescent Depression	96127	G8431 or G8510
Beck Depression Inventory-II (BDI-II)	96127	G8431 or G8510
Center for Epidemiological Studies Depression Scale (CES-D)	96127	G8431 or G8510
Center for Epidemiological Studies Depression Scale for Children (CES-DC)	96127	G8431 or G8510
Patient Health Questionnaire Adolescent Version (PHQ-A)	96127	G8431 or G8510
Patient Health Questionnaire Quick Depression Screen (PHQ-9)	96127	G8431 or G8510
Children's Depression Inventory (CDI)	96127	G8431 or G8510
Reynolds Adolescent Depression Scale (RADS)	96127	G8431 or G8510
Pediatric Symptom Checklist	96127	G8431 or G8510
Maternal (Perinatal) Depression		
Administration and Interpretation of health risk assessment (Postpartum Depression Screening)	96127 HD	G8431 HD or G8510 HD
Prenatal care, at risk assessment (Prenatal Depression Screening)	H1000	H1000/G8431 or G8510
Edinburgh Postpartum Depression Scale (EPDS)	96127 HD	G8431 HD or G8510 HD
Beck Depression Inventory-II (BDI-II)	H1000/96127 HD	H1000/G8431 HD or G8510 HD
Center for Epidemiological Studies Depression Scale (CES-D)	H1000/96127 HD	H1000/G8431 HD or G8510 HD
Patient Health Questionnaire Quick Depression Scale (PHQ-9)	H1000/96127 HD	H1000/G8431 HD or G8510 HD
Parenting Stress Index (PSI)	H1000/96127 HD	H1000/96127 HD
Adolescent Alcohol and Substance Use and Abuse		
Problem-Oriented Screening Instrument for Teenagers (POSIT)	96127	96127
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Tool	96127	96127

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

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

Procedure Codes for Approved Developmental Screening Tools

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

Tier 1: Developmental Screening and Assessment/Evaluation Tools - Approved for Reimbursement -	Recommended CPT Code
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)
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) 96113 for each add'l 30 minutes (limit of 6 units)
Child Development Inventory (CDI)	96112 for first hour (bill 1 unit only) 96113 for each add'l 30 minutes (limit of 6 units)
Connor's Rating Scales (CRS)	96112 for first hour (bill 1 unit only) 96113 for each add'l 30 minutes (limit of 6 units)
Developmental Assessment of Young Children (DAYC)	96112 for first hour (bill 1 unit only) 96113 for each add'l 30 minutes (limit of 6 units)
Devereux Early Childhood - Clinical Form	96112 for first hour (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 (bill 1 unit only) 96113 for each add'l 30 minutes (limit of 6 units)
Early Coping Inventory	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
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)

** 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)*

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:
  - Title 19 children: providers must administer VFC vaccines and are eligible for reimbursement of the administrative fee
  - Title 21 children and State Funded (SF) children: 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		
Service Setting	Services to Bill	
	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, 90714, 90715, 90716, 90721, 90723, 90732, 90734, 90743, 90744, 90747, 90748, Q2035, Q2036, Q2037, Q2038
Stand-Alone Vaccination by Salaried Employee	99211	

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 needs 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 (DOS prior to 4/1/2023)

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#) X	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 002214983

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Patient, John Q.	01 28 2017	M X F	Patient, John Q.

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY SEX: 01 28 2017 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO X PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME: ILLINOIS Health Plan
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE 04/01/2017

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI 9781451500	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. F81.9 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 28 17		11		99391	25	A	100 00	1		ZZ NPI	208000000X 1234567892
2 03 28 17		11		96127	HD	A	25 00	1		ZZ NPI	208000000X 1234567892
3 03 28 17		11		96110		A	16 07	1		ZZ NPI	208000000X 1234567892
4 03 28 17		11		90723		A	23 00	1		ZZ NPI	208000000X 1234567892
5 03 28 17		11		90670		A	17 00	1		ZZ NPI	208000000X 1234567892
6 03 28 17		11		90647		A	17 00	1		ZZ NPI	208000000X 1234567892

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789 X	868B12413900AS	X YES NO	$ 198 07	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (847) 430-6450
04/01/2017 SIGNED DATE	a. NPI b.	Dr John Doe 1234 Main St Des Plaines, IL 60018 a. 1234567892 b. ZZ208000000X

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 1:

- 96110 developmental screen
- 85018 Hemoglobin
- 83655 Lead screening
- 36416 collection capillary blood specimen

Vaccines:

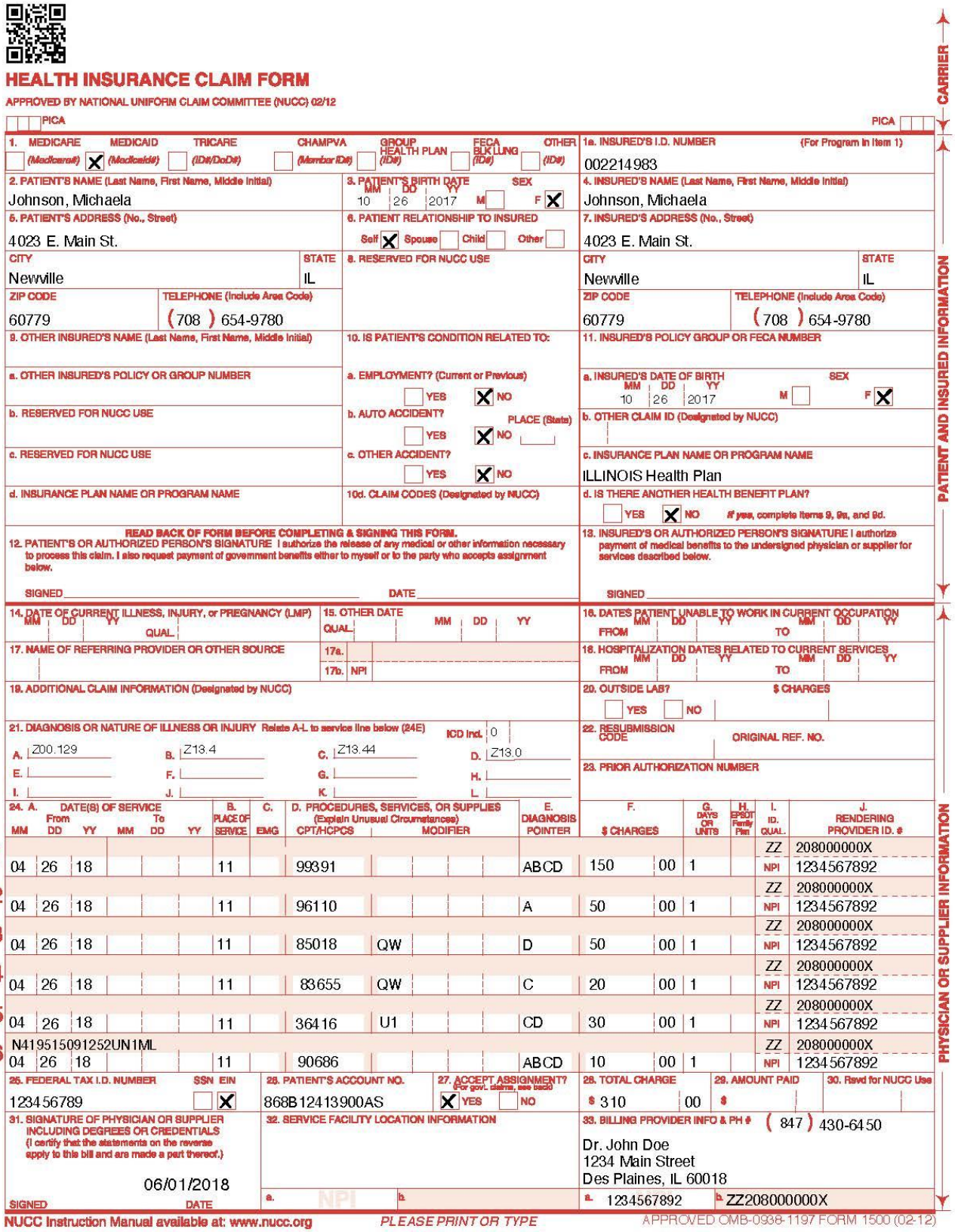
- 90686 Influenza, no preservative quadrivalent
- They will have to return in one month for second flu vaccine.

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 002214983
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson, Michaela	3. PATIENT'S BIRTH DATE MM DD YY: 10 26 2017 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Johnson, Michaela	
5. PATIENT'S ADDRESS (No., Street): 4023 E. Main St.	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 4023 E. Main St.	
CITY: Newville STATE: IL	8. RESERVED FOR NUCC USE
CITY: Newville STATE: IL	
ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780	
ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 10 26 2017 SEX: M [ ] F [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: ILLINOIS Health Plan	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. Z00.129 B. Z13.4 C. Z13.44 D. Z13.0 E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	26	18				11		99391		ABCD	150 00	1		ZZ NPI	208000000X 1234567892
2	04	26	18				11		96110		A	50 00	1		ZZ NPI	208000000X 1234567892
3	04	26	18				11		85018	QW	D	50 00	1		ZZ NPI	208000000X 1234567892
4	04	26	18				11		83655	QW	C	20 00	1		ZZ NPI	208000000X 1234567892
5	04	26	18				11		36416	U1	CD	30 00	1		ZZ NPI	208000000X 1234567892
6	N419515091252UN1ML 04	26	18				11		90686		ABCD	10 00	1		ZZ NPI	208000000X 1234567892

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 868B12413900AS	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 310 00	29. AMOUNT PAID: $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 06/01/2018 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH #: (847) 430-6450 Dr. John Doe 1234 Main Street Des Plaines, IL 60018 a. 1234567892 b. ZZ208000000X		

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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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

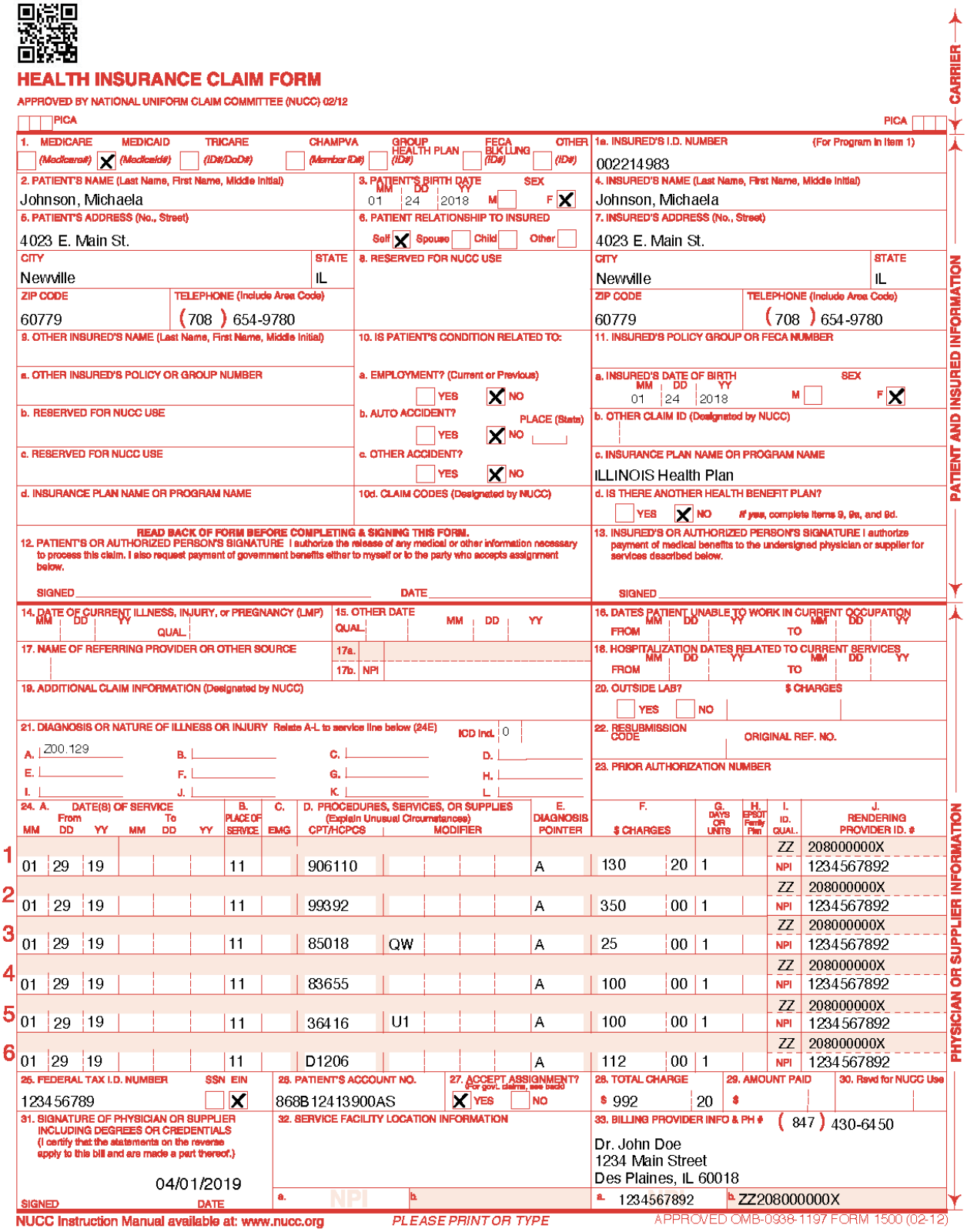
Billing Requirements for Scenario 4:

- 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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 002214983

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson, Michaela

3. PATIENT'S BIRTH DATE MM DD YY: 01 24 2018 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Johnson, Michaela

5. PATIENT'S ADDRESS (No., Street): 4023 E. Main St.

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 4023 E. Main St.

CITY: Newville STATE: IL

8. RESERVED FOR NUCC USE

CITY: Newville STATE: IL

ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780

ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 01 24 2018 SEX M F X

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ILLINOIS Health Plan

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z00.129 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	29	19				11		90611O		A	130	20	1		ZZ	208000000X
																NPI	1234567892
2	01	29	19				11		99392		A	350	00	1		ZZ	208000000X
																NPI	1234567892
3	01	29	19				11		85018	QW	A	25	00	1		ZZ	208000000X
																NPI	1234567892
4	01	29	19				11		83655		A	100	00	1		ZZ	208000000X
																NPI	1234567892
5	01	29	19				11		36416	U1	A	100	00	1		ZZ	208000000X
																NPI	1234567892
6	01	29	19				11		D1206		A	112	00	1		ZZ	208000000X
																NPI	1234567892

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 868B12413900AS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 992 20

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

04/01/2019

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (847) 430-6450

Dr. John Doe
1234 Main Street
Des Plaines, IL 60018

a. 1234567892 b. ZZ208000000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 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

PICA

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#)	X MEDICAID
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	002214983
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Johnson, Michaela
3. PATIENT'S BIRTH DATE MM DD YY / SEX	01 24 2018 / F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Johnson, Michaela
5. PATIENT'S ADDRESS (No., Street)	4023 E. Main St.
6. PATIENT RELATIONSHIP TO INSURED	Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	4023 E. Main St.
CITY / STATE	Newville / IL
8. RESERVED FOR NUCC USE	
CITY / STATE	Newville / IL
ZIP CODE / TELEPHONE (Include Area Code)	60779 / (708) 654-9780
ZIP CODE / TELEPHONE (Include Area Code)	60779 / (708) 654-9780
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	01 24 2018 / M / F X
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES / X NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES / X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	ILLINOIS Health Plan
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / X NO — If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	
15. OTHER DATE QUAL. MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? $ CHARGES	YES / NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	0
22. RESUBMISSION CODE / ORIGINAL REF. NO.	
A. Z00.129 B. C. D. E. F. G. H. I. J. K. L.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	29	19			11		90686		A	50 00	1		ZZ	208000000X
														NPI	1234567892
2	01	29	19			11		90707		A	65 00	1		ZZ	208000000X
														NPI	1234567892
3	01	29	19			11		90716		A	35 00	1		ZZ	208000000X
														NPI	1234567892
4	01	29	19			11		90633		A	25 00	1		ZZ	208000000X
														NPI	1234567892
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789 / EIN X	868B12413900AS	X YES NO	$ 992 20	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (847) 430-6450
04/01/2019 SIGNED DATE	a. NPI b.	Dr. John Doe 1234 Main Street Des Plaines, IL 60018 a. 1234567892 b. ZZ208000000X

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 (DOS prior to 4/1/2023)
- 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 of 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:

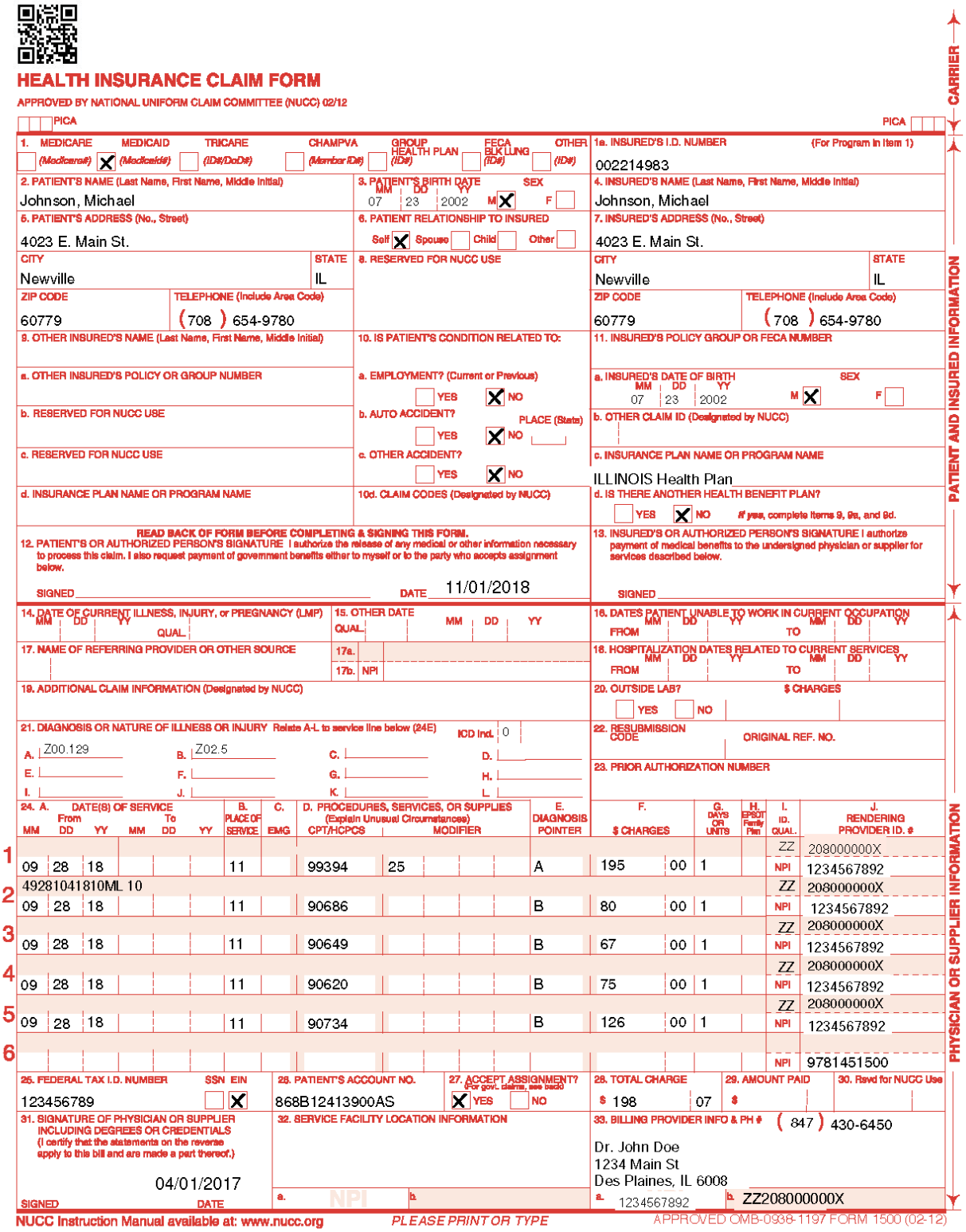
- Bill the appropriate minimal level office visit or other outpatient visit for evaluation and management and bill the specific vaccine procedure codes.
- For vaccination billing, please refer to vaccination billing section above.

Billing Example:

Vaccine	CPT	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)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) [ ] MEDICAID (Medicaid#) [X] TRICARE (ID#/DoD#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (ID#) [ ] FECA BLK LUNG (ID#) [ ] OTHER (ID#) [ ]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 002214983

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson, Michael

3. PATIENT'S BIRTH DATE MM DD YY: 07 23 2002 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Johnson, Michael

5. PATIENT'S ADDRESS (No., Street): 4023 E. Main St.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 4023 E. Main St.

CITY: Newville STATE: IL

8. RESERVED FOR NUCC USE

CITY: Newville STATE: IL

ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780

ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 07 23 2002 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ILLINOIS Health Plan

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE 11/01/2018

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z00.129 B. Z02.5 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	28	18			11		99394	25	A	195 00	1		ZZ	208000000X
														NPI	1234567892
2	49281041810ML 10													ZZ	208000000X
	09	28	18			11		90686		B	80 00	1		NPI	1234567892
3	09	28	18			11		90649		B	67 00	1		ZZ	208000000X
														NPI	1234567892
4	09	28	18			11		90620		B	75 00	1		ZZ	208000000X
														NPI	1234567892
5	09	28	18			11		90734		B	126 00	1		ZZ	208000000X
														NPI	1234567892
6														NPI	9781451500

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 123456789

26. PATIENT'S ACCOUNT NO.: 868B12413900AS

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 198 07

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

04/01/2017

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (847) 430-6450

Dr. John Doe
1234 Main St
Des Plaines, IL 6008

a. 1234567892 b. ZZ208000000X

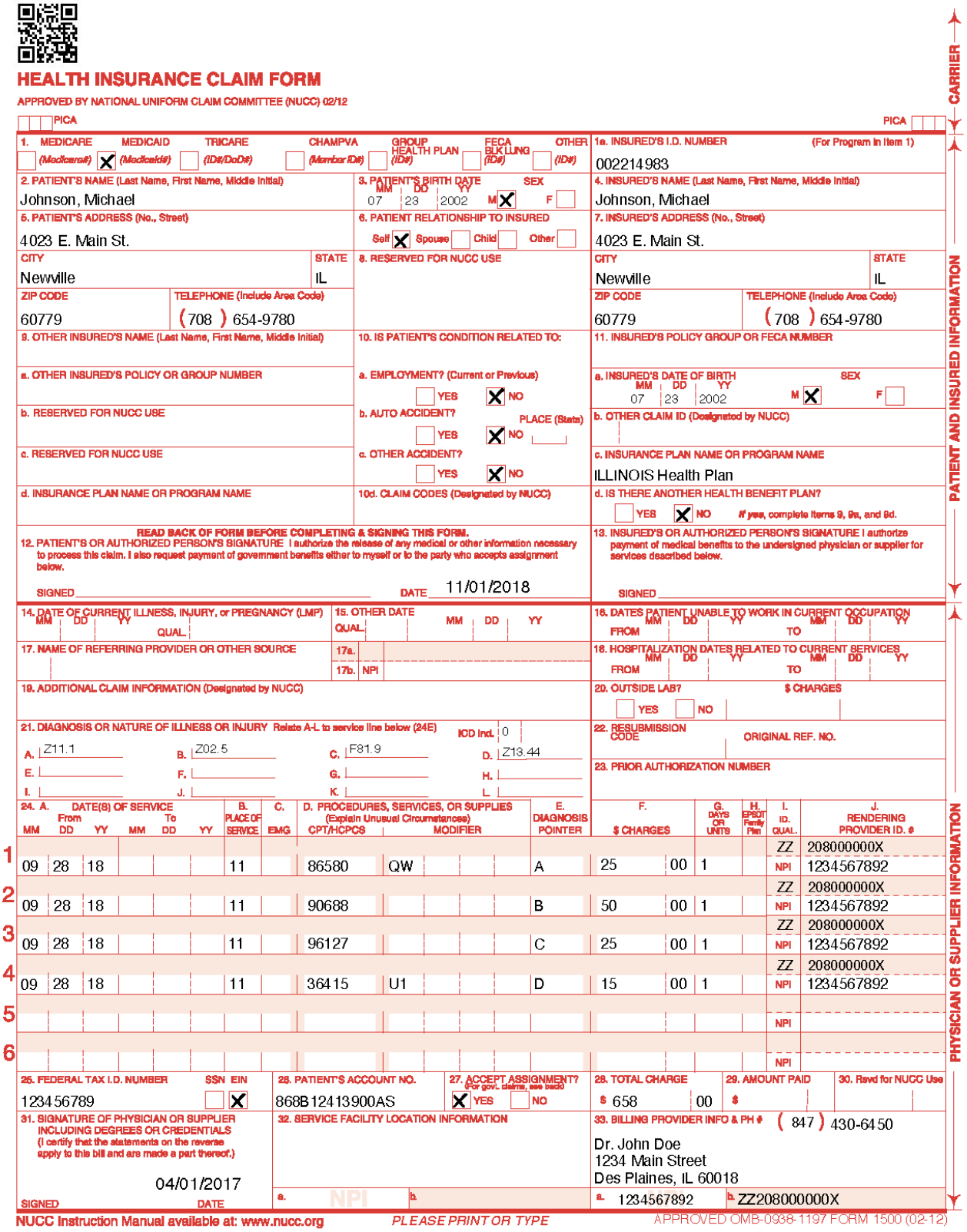
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Scenario 5: Sample Claim (Page 2 of 2)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 002214983

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson, Michael

3. PATIENT'S BIRTH DATE MM DD YY: 07 23 2002 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Johnson, Michael

5. PATIENT'S ADDRESS (No., Street): 4023 E. Main St.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 4023 E. Main St.

CITY: Newville STATE: IL

8. RESERVED FOR NUCC USE

CITY: Newville STATE: IL

ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780

ZIP CODE: 60779 TELEPHONE (Include Area Code): (708) 654-9780

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 07 23 2002 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ILLINOIS Health Plan

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE 11/01/2018

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z11.1 B. Z02.5 C. F81.9 D. Z13.44

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	28	18			11		86580	QW	A	25 00	1		ZZ	208000000X
														NPI	1234567892
2	09	28	18			11		90688		B	50 00	1		ZZ	208000000X
														NPI	1234567892
3	09	28	18			11		96127		C	25 00	1		ZZ	208000000X
														NPI	1234567892
4	09	28	18			11		36415	U1	D	15 00	1		ZZ	208000000X
														NPI	1234567892
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 123456789

26. PATIENT'S ACCOUNT NO.: 868B12413900AS

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 658 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

04/01/2017

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (847) 430-6450

Dr. John Doe
1234 Main Street
Des Plaines, IL 60018

a. 1234567892 b. ZZ208000000X

CARRIER

PATIENT AND INSURED INFORMATION

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IV. 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

i. 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

ii. 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.**

i. 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.

ii. 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. 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.

iii. 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.

NOTE: Effective April 1, 2024, licensed genetic counselors may enroll as Medicaid providers and submit claims for their services. Physicians will be allowed to bill on behalf of genetic counselors until January 31, 2025. Starting with dates of service February 1, 2025 physicians providing genetic counseling services must use the appropriate E&M procedure codes, per CPT guidelines.

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 (AAC) for the drug product plus the appropriate established 340B dispensing fee as noted on the Practitioner Fee Schedule. The exception to this requirement is hospital outpatient claims containing drugs. With the implementation of the EAPG payment methodology, hospitals are only required to report AAC on outpatient claims for 340B drugs when the 340B drug is on the HFS renal dialysis injectable drug listing.

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

i. 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
- 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.Ill. 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:

MCO	Timeframe
Aetna Better Health	Once every 3 years
BCCHP	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 ½) 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 vii Services to Newborns 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.

i. 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.

ii. 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.

iii. 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.

iv. Anesthesia – Other

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

- 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

i. 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 .

ii. 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.

iii. 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.

iv. Surgical Services - Hospital

a) 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.

b) 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.

c) 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.

v. Co-Surgeon/Surgical Assistance

a) 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).

b) 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.”

c) 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.

d) 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 form HFS 1977 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:

This billing guidance is to be followed when Medicaid is the primary payor. If a member has TPL, please refer to **Appendix L: Coordination of Benefits (COB)/Third Party Liability (TPL).**

Individual Maternity Service Billing rules also apply to members with TPL when:

- Multiple Providers who are not in the same provider group render maternity services,
- If the Pregnancy ends early (Miscarriage or premature delivery with less than four Antepartum visits,
- Antepartum care only or Delivery service only---- One or the other

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 Pediatric Services of this billing guide.

- The initial claim is billed with 0500F with U4 modifier- initial prenatal care visit. The U4 modifier will drive reimbursement for the initial prenatal visit effective 10/1/23*.
- Subsequent prenatal office visits are to be billed using the appropriate E&M visit code with the U5 modifier effective 10/1/2023*.

*Note: FQHCs, RHCs and ERCs are still required to follow the T1015 medical encounter code but use all the appropriate coding and modifiers as indicated in this guidance for detail coding lines.

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.

Services unrelated to pregnancy should continue to be documented and billed separately with the appropriate E/M code. DO NOT USE U5 modifier when the service is unrelated to pregnancy.

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 in cases where Medicaid is not the primary payor (Refer to **Appendix L: Coordination of Benefits [COB]/Third Party Liability [TPL] Policies).**

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.

- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59412- ECV effective as of 1/1/2023
- 59514 - Cesarean delivery only
- 59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Procedure for billing multiple births submitted as Individual Maternity Care Services:

1) Vaginal Delivery:

Submit for Baby #1 using the individual maternity procedure code appropriate for vaginal delivery only. Submit for Baby #2 and beyond using the unlisted procedure code and a serrate service line for each additional baby. Enter the description "twin", "triplet" etc. in the NTE segment of the 837P.

2) Cesarean Delivery:

Baby #1 and beyond: Submit (*only once) using the individual maternity service code appropriate for cesarean delivery only.

3) Vaginal delivery, followed by Cesarean delivery:

If one baby is delivered vaginally and the other(s) by cesarean section, bill the correct code for each delivery type with separate charges in the following manner, and attach both delivery reports to the claim.

a. Baby #1: Submit using the individual maternity procedure code appropriate for vaginal delivery only.
b. Baby #2 and beyond: Submit (*only once) using the individual maternity procedure code appropriate for cesarean delivery. Note: Cesarean codes should be reported only once regardless of the number of babies delivered.

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 Birthing Center section of this billing guide.

Postpartum:

Postpartum care begins after the member is discharged from the hospital stay for delivery and extends throughout the postpartum period of 12 months. Providers may bill for a postpartum visit twice during this postpartum period.

- 59430 - Postpartum care code – **effective 10/1/23**
  - 0503F was discontinued by HFS as of 9/30/2023 and should no longer be billed.
- Postpartum bonus payments were introduced effective January 1, 2023. In accordance with the February 21, 2023 provider notice, bonus payments are dependent upon reporting of the actual delivery date on the postpartum visit claim.
- Providers must include the actual delivery date in Loop 2300, Segment DTP*454 'Initial Treatment Date', of the 837P. If filing paper claims using the CMS-1500, complete Box 15 with the qualifier 454 (initial treatment). The provider is eligible for bonus payments if a postpartum visit occurs within the first 26 days following the delivery date, and/or if a postpartum visit occurs within 27-89 days following the delivery date, as reported on the claim. Each of these time periods will have a limit of one payable bonus payment. Payment of a bonus payment for the 27-89 days post-delivery time period is not dependent upon there having been a payment during the first 26-days post-delivery time period. For instances when more than one claim is received during the same time period, the bonus payment will be reimbursed on the first claim received.

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 Practitioner Fee Schedule Key.

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 Practitioner Fee Schedule Key and Lab Rates.

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 Pediatric Services 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 aged 50 and older;
    - African American men aged 40 and older; and
    - Men aged 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 Pediatric Services 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

i. 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)
- a Licensed Clinical Social Worker (LCSW)
- a Licensed Clinical Professional Counselor (LCPC)
- a Licensed Marriage and Family Therapist (LMFT.

Practitioners should refer to the appropriate HFS fee schedules to determine covered billing codes (e.g., Practitioner Fee Schedule and/or Licensed Practitioner of the Healing Arts).

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.

ii. 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.

iii. Psychiatric Services Rendered by a LCP, LCPC, LCSW or LMFT

Certain services rendered by LCPs, LCPCs, LCSWs and LMFTs are reimbursable. This applies to services rendered by these practitioners practicing outside a Behavioral Health Center (BHC), Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Encounter Rate Clinic (ERC), or Rural Health Center (RHC). Refer to the appropriate sections of this Guide when billing for services within any of those settings:

- Community Based Behavioral Services for CMHCs.
- FQHCs, RHCs and ERCs

For services delivered outside of those settings, refer to the Licensed Practitioners of the Healing Arts Fee Schedule for covered services and reimbursement rates.

When psychiatric services are rendered by a LCP, LCPC, LCSW, or LMFT, 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.

Self-administered and self-scored tests of cognitive function, biofeedback therapy, and services identified in 89 Ill. Adm. Code 140.6 are not eligible for reimbursement.

iv. 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.

i. Non-Medicare Eligible Participant

a) 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.

b) 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.

V. 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 NCPDP (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

MCO	PBM	Contact Information
Aetna Better Health® of Illinois	CVS Caremark	888-964-0172
BCBS	Prime Therapeutics	888-274-5218
County Care	MedImpact **Effective 7/1/2023: CVS Caremark**	888-402-1982 800-631-2312
Meridian	CVS Caremark **Effective 1/1/24: Express Scripts**	888-624-1145 833-750-4407
Molina	CVS Caremark	800-364-6331
YouthCare	Envolve Pharmacy Solutions **Effective 1/1/24: Express Scripts**	800-460-8988 833-750-4409

MCO BINs and PCNs

Plan	Carrier	BIN	PCN	Group ID
Aetna Better Health		610591	ADV	RX881A
Blue Cross Community Health Plans		11552	ILCAID	DCFS: MM10 Special Needs Children (SNC): MM11 MLTSS: MM03 ACA: MM09 Disabled Adults (ICP): MM05 Non-Disabled Children/Adults (FHP): MM06 & MM07
CountyCare	**Effective 7/1/2023:**	017142 004336	ASPROD1 MCAIDADV	CCX01 RX23BT
Meridian	**Effective 1/1/24:**	004336 003858	MCAIDADV MA	RX5491 2EHA
Molina	0823/0829/0817	004336	ADV	RX0823/RX0829/RX0817
YouthCare	**Effective 1/1/24:**	020545 003858	RXA383 MA	RXGMCIL01 2EJA

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 Code	Description
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
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear 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 'General Claim Submissions Guidelines' 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
- betadine swabs
- sharp containers
- sterile gloves
- dressing change kits
- flushing syringes
- vial adapters
- extension sets
- IV start kit, tape
- IV cannulas (peripheral line)
- needleless system supplies
- needles
- cassette with tubing
- TPN bag
- administration set with filter
- 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 Illinois HFS DME fee schedule 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

a) 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.

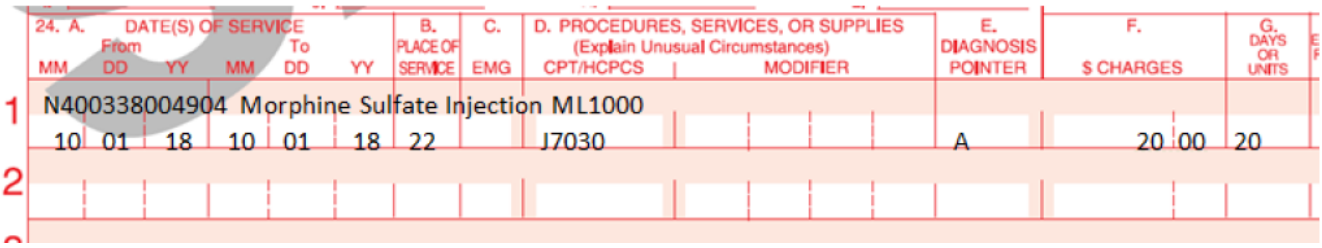
b) 340-B Purchased Drugs

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:



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1 N400338004904 Morphine Sulfate Injection ML1000												
10	01	18	10	01	18	22		J7030		A	20 00	20
2												

viii. HIV and Oral Contraceptives Assessment and Consultation Services

Effective with dates of service beginning on August 1, 2022 (Oral Contraceptives) and January 1, 2023 (HIV Pre- and Post-Exposure Prophylaxis), pharmacists may be reimbursed for the following services to Medicaid MCO members:

- Assessment and consultation of patients and the dispensing of hormonal contraceptives
- Initiation, dispensing, or administration of drugs, laboratory tests, assessments, referrals and consultations of HIV pre-and post-exposure prophylaxis

These new services have specific IMPACT registration requirements and are provided and billed outside of the PBM and POS systems that pharmacists traditionally use for billing. They are billed on a professional claim (CMS 1500 or 837P), NOT an NCPDP claim, and are submitted directly to the MCO. A educational video on these new services can be found here.

a) IMPACT Enrollment

Currently, individual pharmacists do not need to be enrolled in IMPACT if they are only dispensing prescriptions to Medicaid members as an employee/contractor of an enrolled pharmacy. **However**, to provide the new HIV/Contraceptive assessment and prescribing services, individual pharmacists **must** be enrolled in IMPACT as individual practitioners and be associated with an enrolled pharmacy.

Before enrollment, the prescribing pharmacist must complete Illinois-specific training, as there is an enrollment step that requires them to attest they have completed the training and the date it was completed. Pharmacists should enroll with their individual NPI and taxonomy code 183500000X.

IMPACT Provider Type	IMPACT Specialty	IMPACT Subspecialty	Legacy Provider Type	Legacy COS
Pharmacists	Pharmacist	No Subspecialty	105	132 HIV Assessment and Consultation 103 Family Planning Assessment/Counseling

NOTE: Claims cannot be submitted to an MCO until the pharmacist receives their HFS Provider Information Sheet from IMPACT, noting the addition of Category of Service 132 (HIV services) and/or Category of Service 103 (Contraceptive Services).

b) Billing and Coding Guidance

Claims are to be submitted using the CMS 1500 or 837P claim format and should follow the general claim submission guidelines in Part A of this Billing Manual. All claims must include a referral for services using the corresponding IDPH standing order:

- HIV services IDPH Standing Order
- Contraceptive Services IDPH Standing Order

The following table outlines specific required claim elements, including allowable procedure codes (beyond those outlined as required in Part A). NOTE: Any drugs dispensed continue to be billed through the Pharmacy Billing System.

HIV and/or Contraceptive Services Claim Elements

Claim Element	Description	CMS 1500 Field	837P Loop
Billing Provider	Pharmacy name/address and NPI	33 and 33a	2010AA
Rendering Provider	Pharmacist Name and NPI	24J	2420A
Referring Provider	Name/NPI of Physician providing Standing Order (see above IDPH links)	17 and 17b	2310A
Place of Service	POS 01 (no other POS is accepted)	24B	2400
Procedure Code(s) ** when providing these codes for contraceptive services, use the FP modifier with each code	99401 – Preventive Medicine counseling/risk factor reduction (15 mins)	24D	2400
	99202 – Office/OP visit, E&M of new patient (15 – 29 mins)		
	99203 - Office/OP visit, E&M of new patient (30-44 mins)		
	99211 - Office/OP visit, E&M of established patient (15 – 29 mins)		
	99212- Office/OP visit, E&M of established patient (30-44) mins		

VI. Community Based Behavioral Services (CBS)

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.

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 Ill. 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 Ill. 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 Ill. 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.

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**
Behavioral Health Clinic	Facility, Agency, Organization	027	Certain procedure codes in GROUP B require the provider to be designated in IMPACT with specialties of: • Crisis Stabilization • Mobile Crisis Response • Intensive Outpatient'	Children and adolescents 261QM0855X 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

i. 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.

ii. Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to an 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

i. 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.

7. 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.

a) Services and Procedure Codes

As per the **HFS Community Behavioral Services Handbook** , the following procedure codes are to be used for billing services in Group A, Group B and Group C:

Service Name	HCPC Code	Modifiers		Units
		1	2	
Group A - billable by BHC and CMHC and IPs | See Table 1 and Table 2 for provider eligibility				
Integrated Assessment and Treatment Planning (IATP)	H2000	HN		1/4 hr
Integrated Assessment and Treatment Planning (IATP)	H2000	HO		1/4 hr
IATP: Review and Update	H2000	HN	SF	1/4 hr
IATP: Review and Update	H2000	HO	SF	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: Psychological Assessment	H2000	AH		1/4 hr
IATP: Psychological Assessment	H2000	HP		1/4 hr
IATP: LOCUS Assessment	H2000	HN	HE	1/4 hr
Crisis Services				
Crisis Intervention	H2011	HN		1/4 hr
Therapy/Counseling Services				
Therapy/Counseling - Individual	H0004	HN		1/4 hr
Therapy/Counseling - Individual	H0004	HO		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	HO	HQ	1/4 hr
Therapy/Counseling - Family	H0004	HN	HR	1/4 hr
Therapy/Counseling - Family	H0004	HO	HR	1/4 hr
Group B - billable by BHC and CMHC- See Table 3 for provider eligibility				
General Medicaid Rehabilitation Option Services				
Community Support - Individual	H2015	HM		1/4 hr
Community Support - Individual	H2015	HN		1/4 hr
Community Support - Individual	H2015	HO		1/4 hr
Community Support - Group	H2015	HM	HQ	1/4 hr
Community Support - Group	H2015	HN	HQ	1/4 hr
Community Support - Group	H2015	HO	HQ	1/4 hr

Service Name	HCPC Code	Modifiers		Units
		1	2	
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
Medication Training - Group	H0034	52	HQ	1/4 hr
Medication Training - Group	H0034	SA	HQ	1/4 hr
Assessment and Treatment Planning				
IATP: LPHA Review ***Effective with DOS beginning 7/1/22***	H2000	SC		1/4 hr
Targeted Case Management Services				
Case Management - Client-Centered Consultation	T1016	HM	HS	1/4 hr
Case Management - Client-Centered Consultation	T1016	HN	HS	1/4 hr
Case Management - Mental Health	T1016	HM		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	HO	TS	1/4 hr
Crisis Services				
Crisis Intervention – Team**	H2011	HN	HT	1/4 hr
Crisis Stabilization**	T1019	HN		1/4 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	HO	HB	1 hr
Mental Health Intensive Outpatient - Child Program**	S9480	HO	HA	1 hr
Violence Prevention Community Support Team (VP-CST) – Individual	H0037	Modifier corresponding to staff level		1/4 hr
Violence Prevention Community Support Team (VP-CST) – Group	H0037	HQ	Modifier corresponding to staff level	1/4 hr
Behavioral Health Screening Services				
Developmental Screening**	96110	TF		Event
Developmental Testing**	96112	TF		Event
Depression Screening – screening is documented as positive and follow-up plan is documented	G4831	TF		Event

Service Name	HCPC Code	Modifiers		Units
		1	2	
Depression Screening – screening is documented as negative; follow-up plan is not required	G8510	TF		Event
Mental Health Risk Assessment**	96127	TF		Event
Prenatal Care At-Risk Assessment**	H1000	TF		Event
Family Support Program (FSP) Services: BILLABLE BY CCSOs only (see Pathways to Success)				
FSP Application Assistance	G9012	HN	SE	1/4 hr
FSP Clinical Case Participation	T1016	HN	SE	1/4 hr
FSP Family Support Services	T1999			Event
FSP Therapeutic Support Services	H0046			Event
Group C - billable by CMHC only See Table 4 for provider eligibility				
Telehealth Services				
Telepsychiatry: Originating Site**	Q3014	HN		Event
Intensive Services Requiring Program Certification				
Assertive Community Treatment (ACT) - Individual*	H0039			1/4 hr
Assertive Community Treatment (ACT) - Group*	H0039	HQ	Modifier corresponding to staff level	1/4 hr
Psychosocial Rehabilitation – Individual**	H2017	HM		1/4 hr
Psychosocial Rehabilitation – Individual**	H2017	HN		1/4 hr
Psychosocial Rehabilitation – Individual**	H2017	HO		1/4 hr
Psychosocial Rehabilitation – Group**	H2017	HM	HQ	1/4 hr
Psychosocial Rehabilitation – Group**	H2017	HN	HQ	1/4 hr
Psychosocial Rehabilitation – Group**	H2017	HO	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.*

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

b) 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.***
H9	Forensic Service
HA	Child Program
HB	Adult Program
HE	LOCUS assessment
HH	Substance Use Disorder (SUD) worker
HJ	Employment Supports
HK	High-risk mental health program
HM	RSA
HN	MHP
HO	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

c) 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 *home* ***(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
	27 - Outreach Site/Street (effective 10/1/23)
	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

d) Rendering and Billing Providers

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.

e) 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.

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 roll up 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	HO	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	HN	11	2
1	H2011	HN	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	HM	99	2
1	H2015	HM	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	HM	99	5

f) 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 - Effective 8/1/2018
- Crisis Intervention Services- Mobile Crisis Response 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	Facility, Agency, Organization	027	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	Modifiers		Units	Place of Service Rules	Form Type	Approval for member to participate from HFS required
		1	2				
Intensive In-Home - Clinical Only	H2020	TG	TG	Event	04 – Homeless Shelter 12 – home 13 – Assisted Living Facility 14 – Group Home	837P	OBRA Code = RI
Intensive In-Home - Support Only	H2020	SC	SC	Event		837P	OBRA Code = RI
Intensive In-Home - Both Clinical and Support	H2020	TG	SC	Event		837P	OBRA Code = RI

Intensive In-Home Payment and Claiming Cycle

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

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:

Care Coordination and Support (CCS): 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.

Care Coordination and Support Organization (CCSO): 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, Organization (FAO)	Community Mental Health Center	036	Home and Community Based Services	Children's Services	121	• Family Peer Support • Respite • Therapeutic Mentoring
				Intensive Home-Based	121	• Intensive Home-Based
				Care Coordination & Support	122	• CCS • Individual Support Services* (T1999) • Therapeutic Support Services*(H0046)
Facility, Agency, Organization (FAO)	Behavioral Health Clinic	027	BHC Home and Community Based Services	Children's Services	121	• Family Peer Support • Respite • Therapeutic Mentoring
				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**	
Care Coordination & Support –Tier 1, High Fidelity Wraparound (HFW)	MHP	G9001	122	99 -Other Place of Service	Only 1 Unit every 26 days	
Care Coordination & Support –Tier 2, Intensive Care Coordination (ICC)	MHP	G9002	122		Only 1 Unit every 26 days	

These services (G9001 and G9002) 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
- The HFS authorization file does NOT indicate the eligibility for other Pathways Specific Services outlined in Table D below.

Pathways Specific Services - billable by BHC and CMHC - Table D							
Service Name	**Staff Level**	**HFS COS**	**Place of Service Codes***	**HCPCS Code**	**Modifiers**		**Units/Maximums**
					1	**2**	
Family Peer Support	RSA	121	On-site and Off-Site POS	H0038	HS		¼ 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			¼ hour / 96 units daily
Intensive Home Based (IHB) – Clinical	LPHA	121	On-site and Off-Site POS	S9482	TF		¼ hour / 96 units daily
Intensive Home Based (IHB) – Clinical	QMHP	121	On-site and Off-Site POS	S9482	HO		¼ hour / 96 units daily
Intensive Home Based (IHB) – Support	MHP	121	On-site and Off-Site POS	S9482			¼ hour / 96 units daily
Pathways Specific Services - billable by BHC and CMHC participating in Child and Family Teams							
IATP: Child and Family Team Participation	RSA or higher	006 034 058 059	On-site and Off-Site POS	G9007			Event: < or = 90 mins.

Pathways Specific Services - billable by BHC and CMHC - Table D							
Service Name	Staff Level	HFS COS	Place of Service Codes*	HCPCS Code	Modifiers		Units/Maximums
					1	2	
		116					
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.*

*** 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.*

E. Psychiatric Collaborative Care Model Services (CoCM)

CoCM is an evidence-based model for integrating behavioral health into primary care settings using a person-centered, team-based approach. The goal of CoCM services is to extend the capabilities of primary care practices to identify and treat customers with low to moderate behavioral health needs. CoCM is intended for customers with common behavioral health conditions that require systematic follow-up due to their chronic nature, including but not limited to: mild to moderate depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders (SUD).

The CoCM team is led by a primary care provider (PCP) and includes a behavioral health care manager (BHCM) and a psychiatric consultant. The team develops, implements, and regularly monitors a person-centered care plan, making referrals to specialized services when necessary. The model requires the use of validated screening tools and a patient registry. Five core principles define effective collaborative care and are necessary for an effective implementation of the model:

- Person-centered care: the customer is part of the treatment team and makes the ultimate decision regarding their treatment.
- Measurement based treatment-to-target strategy: validated tools are used for the measurement of customer symptoms and needs.
- Population-based care: the use of a patient registry to allow the team to monitor the customer's outcomes over time.
- Evidence-based treatment: treatments offered to customers are evidence-based (e.g., medications, brief interventions).
- Accountable care: the team is accountable for the customer's care, including the quality of care and clinical outcomes.

More information on the CoCM model, care team composition and service delivery requirements can be found in HFS' Psychiatric Collaborative Care Model Guidelines.

i. Provider Enrollment

The table below provides IMPACT registration details for providers seeking reimbursement for CoCM services. It should be noted that providers must attest to providing CoCM services consistent with the core principles and specific service delivery requirements outlined in HFS' CoCM guidelines.

CoCM IMPACT Provider Enrollment

IMPACT Enrollment Type	IMPACT Provider Type	Specialty	Subspecialty	Legacy Provider Type	Legacy Category of Service
Individual/Sole Proprietor	Physician	Behavioral Health Integration	Collaborative Care	010	001
	Advanced Practice Nurse	APN Behavioral Health Integration	Collaborative Care	016	001
Rendering/Servicing Provider	Physician Assistant	Physician Assistants	Collaborative Care	089	001
Facility/Agency/ Organization (FAO)	Public Health Department	Certified Health Departments	Collaborative Care	052	001
	Clinic	School-Based/Linked Health Clinic	Collaborative Care	056	104
		Federally Qualified Health Center	Collaborative Care	040	104
		Rural Health Clinic	Collaborative Care	048	104
		Encounter Rate Clinic	Collaborative Care	043	104

ii. Coding Requirements

CoCM services are reimbursed as a bundled monthly payment based on the care management activities rendered by provider team members during a calendar month. Providers are expected to continue delivering medically necessary CoCM services during a given month, even after the time threshold to bill CoCM is met. However, after completion of the minimum staff time required to bill, providers may submit the claim and need not hold the claim until the end of the month.

CoCM services are billed under the NPI of the PCP serving as team lead or the NPI of the entity employing the PCP serving as team lead. The PCP or entity is responsible for reimbursing team members, who can be employees or contracted staff. CoCM reimbursement rates can be found on the HFS Practitioner Fee Schedule.

CoCM Allowable Billing Codes		
CPT Code	**Description**	**Maximum Monthly Units**
99492	First month of collaborative care, 70 minutes	1
99493	Subsequent month of collaborate care, 60 minutes	1
99494	Each additional 30 minutes of collaborative care	2
G0512*	Single monthly (inclusive of all time frames) rate for 60 minutes or more of collaborative care in FQHC, RHC or ERC settings	1

*CoCM services provided by an FQHC, RHC or ERC do not qualify as an encounter and should be billed outside of the clinic's established encounter rate.

To avoid any duplication of services, CoCM services should not be provided to:

- Members receiving regular case management services as a component of a treatment plan from another provider;
- Members enrolled in the Pathways to Success program; or
- Members receiving Assertive Community Treatment (ACT) services

VII. Substance Use Prevention and Recovery Services (SUPR)

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, Specialty, Subspecialty and Categories of Service

IMPACT Provider Type	IMPACT Specialty	IMPACT Subspecialty	Legacy Provider Type	Legacy COS
Community Addiction Clinic	Professional Addiction Services	Alcohol and Substance Abuse Rehabilitation Methadone Clinic	075	035 Alcohol and Substance Abuse Rehab. Services 106 Methadone Clinic

Although COS is not directly added to a claim submitted to an 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.

i. 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.

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 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	837I	Per Diem
Rehabilitation - Child (age 20 or under)	Level III.5	837I	Per Diem
Adolescent Residential	Level III.5	837I	Per Diem
Detoxification	Level III.5	837I	Per Diem
Withdrawal Management Waiver (Withdrawal Management Waiver)	All levels	837I	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 Service Billing Codes for 837P

Service Name	Procedure Code	Modifier	Unit	Place of Service*	Approval for Member to Participate in HFS?	Taxonomy
Admission and Discharge Assessment	H0002		¼ hour	02, 03, 10, 21, 22, 55, 57, 99	N/A	261QR0405X or 276400000X
Psychiatric Evaluation	90791		Event	02, 03, 10, 21, 22, 55, 57, 99	N/A	261QR0405X or 276400000X
Psychotropic Medication Monitoring	H2010		¼ hour	02, 03, 10, 21, 22, 55, 57, 99	N/A	261QR0405X or 276400000X
Individual-Therapy/Counseling, Substance Abuse	H0004		¼ hour	02, 03,10, 22,57,99	N/A	261QR0405X or 276400000X
Group-Therapy/Counseling Substance Abuse	H0005		¼ hour	02, 03,10,22,57,99	N/A	261QR0405X or 276400000X
Individual-Intensive Outpatient, Substance Abuse	H0004	TF	¼ hour	02, 03,10,22,57,99	N/A	261QR0405X or 276400000X
Group-Intensive Outpatient, Substance Abuse	H0005	TF	¼ hour	02,03,10,22,57,99	N/A	261QR0405X or 276400000X
Medication Assisted Treatment (MAT) Methadone Treatment	H0020		Event	11, 55	N/A	261QM2800X
Peer Recovery Support	H2014		¼ hour	02,10,11, 55, 99	N/A	261QR0405X or 276400000X
Case Management Waiver SUD (Case Management Waiver)** (age 21 +)	H0006		¼ hour	11, 55, 99	OBRA = RC	261QR0405X or 276400000X
Case Management Waiver SUD (Case Management Waiver)** (age 20 & under)	H0006	HA	¼ hour	11, 55, 99	OBRA = RC	261QR0405X or 276400000X

**With the exception of MAT services (H0020), all SUPR professional services can be billed via telehealth, using either POS 02 (telehealth location other than patient's home) or POS 10 (telehealth for patient at home), and either the modifier GT (services delivered via audio and video) or 93 (services delivered via audio only).*

***Refer to 1115 Waiver Rules*

Additional professional claims (837P) claim submission requirements:

1. MAT services (H0020) 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 SUPR 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.
5. SUPR providers are advised to either suppress the rendering loop (2310B) for 837P claim submissions or submit the NPI for the SUPR facility site in the rendering loop. DO NOT submit the individual clinician NPI in the 2310B rendering provider loop.

iii. Institutional Claims (837I)

The following billing codes (Table 4) will be accepted for all institutional/residential SUPR services:

TABLE 4: SUPR Service Billing Codes for 837I

Table 4. SUPR Service Billing Codes for 837I						
Service Name	**Revenue Code**	**Procedure Code**	**Modifier**	**Approval for Member to Participate in HFS?**	**Taxonomy**	**Type of Bill**
Rehabilitation – Adult (age 21+)	944 or 945	H0047		N/A	32450000X or 325S0500X	086X, 089X
Rehabilitation – Child (age 20 or under)	944 or 945	H0047	HA	N/A	32450000X or 325S0500X	086X, 089X
Adolescent Residential	944 or 945	H2036		N/A	32450000X or 325S0500X	086X, 089X
Detoxification	944 or 945	H0010		N/A	32450000X or 325S0500X	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 inpatient hospital providers 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 = XX**3**) or Interim Final (FL 4 Type of Bill = XX**4**), 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 the 'statement through' date **must be the same month** when billing interim claims. For stays under 30 days (Bill Type XX1), the claim can cross months. 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:

Example 1:

Incorrect Billing

CLM*TMGMH19146000H000000*3735***89>A>1**C*Y*Y~ ------ **Bill Frequency 1**
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>>>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**
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:

CLM*TMGMH1915800YBU00000*2280.59***89>A>4**C*Y*Y~ **------Frequency 4**
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>>>16~ - Provider billed 16 -Incorrect number- 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*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**
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~ **Needs to be 15 because HFS does not follow 'per treatment' –**
DTP*472*RD8*20190501-20190516~ **HFS is follows inpatient rules Room and Board accommodation rules**
REF*6R*1~

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 Inpatient Hospital Interim Claims coding guidance in this manual. The month statement from date and the month of statement through date **must be the same month**.
    - Revenue codes 944 or 945 are considered accommodation codes and must follow the same rules as inpatient hospital interim billing. See examples below.
- 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

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**
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~
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>>>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~
LX*3~ **Each individual date of service is no longer allowed**
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~
LX*5~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*D8*20190503~
REF*6R*5~

Correct Billing would result in 3 claims:

Claim 1

CLM*TMGMH19146000H000000*3735***89>A>**2****C*Y*Y~ **------ Bill Frequency 2**
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~
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~
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**
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*01~

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**
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.

D. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons who are at risk of developing substance use disorders or have substance use disorders including, but not limited to, an addiction to alcohol, opioids, tobacco, or cannabis. SBIRT services include all of the following:

1. Screening to quickly assess the severity of substance use and to identify the appropriate level of treatment.
2. Brief intervention focused on increasing insight and awareness regarding substance use and motivation toward behavioral change.
3. Referral to treatment provided to those identified as needing more extensive treatment with access to specialty care.

SBIRT services are covered for members aged 6 through 64 when provided by an eligible IMPACT-enrolled provider, and are effective with dates of service beginning January 1, 2022.

i. Community Based SBIRT Services

a) Qualified Community-Based SBIRT Providers

The following enrolled providers are considered eligible for reimbursement for SBIRT services when delivered within their scope of practice and HFS SBIRT requirements:

- Physicians

- Physician Assistants (PA)
- Advanced Practice Nurses (APN)
- Licensed Clinical Psychologists (LCP)
- Licensed Clinical Social Workers (LCSW)
- Licensed Clinical Professional Counselors (LCPC)
- Licensed Marriage and Family Therapists (LMFT)
- Local Health Departments
- Federally Qualified Health Centers (FQHCs), Encounter Rate Clinics (ERCs) and Rural Health Clinics (RHCs) billing a behavioral health encounter

b) Community-Based SBIRT Service Requirements

Providers delivering SBIRT services to HealthChoice MCO members must:

- Utilize either the Alcohol Use Disorders Identification Test (AUDIT) or Drug Abuse Screening Test (DAST) screening tool;
- Provide immediate face-to-face feedback to the customer regarding the screening results; and
- Retain a copy of the customer's AUDIT or DAST in the customer's clinical record, including screening results.

For SBIRT screens that result in a positive screen, the provider must also:

- Educate the customer regarding the negative consequences of high-risk behaviors associated with alcohol and drug use, seeking to motivate the customer toward behavioral change;
- As clinically appropriate, use brief intervention techniques to engage the customer in a joint decision-making process related to needed behavior changes; and
- As clinically appropriate, provide a referral to specialized substance use disorder (SUD) treatment and a follow-up plan with the customer to support and motivate change.

Referral for Treatment

SBIRT services that result in a clinically appropriate referral for specialized SUD services must be made to a Department of Human Services/Substance Use Prevention and Recovery (DHS-SUPR) licensed community-based provider of SUD treatment services.

c) Qualifying Community-Based SBIRT Procedure Codes

SBIRT services should be billed using the CMS-1500 or 837P claim format using the following HCPCS codes based on the screening outcome and time spent with the member. Note: A qualified provider may only bill one SBIRT HCPCS code, per customer, per day.

Procedure Code	Description	Service Time/Unit
G2011	Alcohol and/ or substance (other than tobacco) abuse structured screening/assessment and brief intervention	5 to 14 minutes
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention	15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention	Greater than 30 minutes
H0049	Alcohol and/ or drug screening (Negative Screen)	Event

ii. Initiation of Medication for the Treatment of Opioid Use Disorder in a Hospital Emergency Department

Hospitals seeking reimbursement for initiation or induction of buprenorphine for the treatment of Opioid Use Disorder (OUD) in the emergency department (ED) setting must perform and document the following:

1) An assessment to determine the individual has an OUD and appropriateness for Medication for Opioid Use Disorder (MOUD), a plan for initiating MOUD if appropriate, and patient education regarding MOUD, treatment services, and overdose prevention.

2) Initiation of buprenorphine must occur in the emergency room and under appropriate medical supervision if the individual is in withdrawal or post-overdose. If the individual is not in withdrawal, a clinician may initiate buprenorphine via a home induction with a prescription at discharge. Medication management and prescribing must be in alignment with best practices and individuals should be prescribed MOUD until their follow-up appointment.

3) Referral for follow-up and ongoing care is a best practice for this service and should occur prior to discharge, consisting of a "warm handoff" to a community-based SUD treatment provider for follow up care or, when a "warm handoff" is not possible, connection to follow-up care should be arranged through the Medication Assisted Recovery Program (MAR NOW).

Hospitals can bill for initiation of MOUD using HCPCS Code G2213 as an add-on to the primary procedure code submitted on the 837I claim format. Reimbursement for G2213 will be made consistent with MCO EAPG pricing reimbursement methodologies.

Procedure Code	Description	Service Unit
G2213	Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services **(list separately in addition to code for primary procedure).**	Event

VIII. Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program

A. Purpose

The purpose of this section is to outline current policies and procedures for billing by Certified Community Behavioral Health Clinics (CCBHCs) approved by HFS for participation in the Illinois CCBHC Medicaid Demonstration Program (Demonstration). The Illinois CCBHC Demonstration began operating on October 1, 2024.

B. Provider Type

CCBHC services must be provided by a clinic approved by HFS for participation in the Demonstration and enrolled in IMPACT as legacy Provider Type 113 – Certified Community Behavioral Health Clinics.

C. IMPACT Enrollment Requirements

i. Provider Type, Specialty, Subspecialty, and Categories of Service

All CCBHCs participating in the Demonstration must be registered in the State's IMPACT system. Designated Collaborating Organizations (DCOs) rendering CCBHC Prospective Payment System (PPS) covered services pursuant to an agreement with the CCBHC are not required to be registered in IMPACT for the purposes of CCBHC billing.

CCBHCs must be enrolled with the appropriate specialty, subspecialty(ies), and categories of service (COS), consistent with the table below. All CCBHCs must ensure COS 146 is registered on their provider enrollment; COS 146 is used to bill for the CCBHC daily encounter rate (i.e., PPS). The additional COS (i.e., COS 121 and COS 126) are optional services a CCBHC may add to their provider enrollment; COS 121 and COS 126 services are not included in the CCBHC PPS and are billed fee-for-service (see Allowable Fee-for-Service section below).

IMPACT Provider Type	IMPACT Specialty	IMPACT Subspecialty	Legacy Provider Type	Legacy COS
Certified Community Behavioral Health Centers	CCBHC Services	No subspecialty	113	146
Certified Community Behavioral Health Centers	CCBHC Services	Methadone*	113	146
Certified Community Behavioral Health Clinics	CCBHC Home and Community Based Services	Children's Services	113	121
Certified Community Behavioral Health Clinics	CCBHC Home and Community Based Services	Intensive Home Based Services	113	121
Certified Community Behavioral Health Clinics	CCBHC Adaptive Behavior Support	No subspecialty	113	126

**Methadone is a covered CCBHC PPS service (i.e., billed as a detail service code on a CCBHC claim along with the T1040 encounter code) that may be provided by CCBHCs, but is not required. Methadone services can only be provided by providers appropriately licensed by the Department of Human Services, Division of Substance Use Prevention and Recovery (DHS-SUPR) and with the appropriate Drug Enforcement Agency (DEA) license. Providers must add the methadone subspecialty to their IMPACT enrollment to bill for methadone (H0020).*

ii. Taxonomy

The CCBHC's NPI must be registered with the following taxonomy: 261QC1500X – Clinic/Center Community Health. All services billed by the CCBHC provider type (PT 113) must use this taxonomy.

D. Covered CCBHC PPS Services

i. Required Service Categories

CCBHCs must provide the following nine core service categories, either directly or through a formal DCO arrangement:

1. Crisis services;
2. Screening, assessment, and diagnosis, including risk assessment;
3. Customer-centered treatment planning;
4. Outpatient mental health and substance use services;
5. Outpatient clinic primary care screening and monitoring;
6. Targeted case management;
7. Psychiatric rehabilitation services;
8. Peer support and counselor services and family supports; and,
9. Intensive, community-based mental health care for members of the armed forces and veterans.

HFS has further defined the service requirements within each of these nine categories. Covered CCBHC PPS services are reimbursed to CCBHCs as part of the clinic's daily encounter rate. CCBHCs are responsible for billing for covered CCBHC PPS services delivered by any DCO partners; reimbursement to the DCO for services rendered is established in the formal agreement between the CCBHC and the DCO.

ii. Charges

Providers may only bill the MCO after the service or item has been provided. The CCBHC will be reimbursed at the all-inclusive PPS daily encounter rate established and updated annually by HFS, except when billing allowable fee-for-service charges listed below. Outside of these listed exceptions, CCBHCs may not bill fee-for-service for any covered CCBHC PPS service for a Medicaid MCO member.

iii. Definition of Encounter

A billable CCBHC encounter (i.e., the PPS encounter denoted with the T1040 billing code) is defined as the delivery of at least one unit of service from the qualifying list of covered CCBHC PPS services ("CCBHC Billing Code List"), maintained on the HFS website here. Only one CCBHC encounter per customer per day can be billed to the MCO. Note this may differ from Fee-for-Service billing to HFS.

E. Allowable Fee-for-Service Billing

CCBHCs have the option to add the appropriate specialty/subspecialty combinations, consistent with the provider enrollment table above, to deliver Adaptive Behavior Support (ABS) services and/or Pathways to Success home and community-based services (Pathways HCBS). These services are not covered under the CCBHC PPS and must be billed fee-for-service. ABS and Pathways HCBS services are paid according to their existing, respective fee schedules. ABS services and rates are found on the ABS fee schedule. Pathways HCBS services are found within the Community Based Behavioral Health Service (CBS) fee schedule.

Fee-for-service claims for ABS and Pathways HCBS services are to be submitted according to existing requirements for those categories of service and MUST be submitted separately from claims for CCBHC PPS covered services. CCBHC claims with ABS or Pathways HCBS services included as detail billable codes under a T1040 service line 1 will reject or deny.

F. Coding Requirements

i. General Coding Information

Providers should 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. CCBHC Specific Billing Information

- Required Encounter Code: All CCBHC claims covered by the PSS encounter rate (COS 146) must have the required CCBHC encounter code (T1040) on the first service line of the 837P claim, along with the clinic's assigned encounter rate. The first service line must denote place of service '99' and should never have a modifier present. The unit of service for the T1040 code is always equal to '1.'
- Detail Billing Codes: CCBHC claims must have subsequent service lines completed to include the procedure codes of the actual services rendered. If an acceptable detail line is not provided, the claim will be denied. All procedure code details for PPS-covered services delivered to the member on that date of service must be included on the claim. The charges listed on the detail service code lines may reflect the provider's usual and customary charges for the services; however, the detail codes will be reimbursed at $0.00 as the provider will be reimbursed their established encounter rate (reported on service line 1). Each detail service line must include the true units of service delivered, based on the parameters of the service code.
- Place of Service: Except for the T1040 on the first service line, all CCBHC claims should be submitted using the true place of service (POS) location from where the service was rendered by reporting the appropriate CMS 2-digit POS code. If the POS denotes telehealth (POS 02 or 10), the service line MUST include the appropriate telehealth modifier (GT or 93) or the claim will reject or deny.
- Billing Provider: All CCBHC claims must have the rendering/servicing CCBHC's NPI in the billing provider loop, 2010AA.
- Rendering Provider: The rendering provider loop should be left blank on CCBHC claims.
- Ordering/Referring Provider: Ordering and referring provider information is not required for CCBHC claims. Loops 2420E and 2310A should be left blank.
- Diagnosis Codes: Claims must include an ICD-10 diagnosis code. There are no limitations on diagnosis codes for inclusion on a CCBHC claim.

- Procedure Code Modifiers: CCBHCs should apply the following rules to their claims:
  - Never include a modifier on the first service line (i.e., T1040 line).
  - On subsequent detail service code lines, include the modifier XP to indicate when the service was delivered by a DCO rather than the CCBHC directly.
  - On subsequent detail service code lines, use the appropriate telehealth modifier (GT or 93) if the service was delivered via telehealth. If a telehealth modifier is used, the service line MUST include the appropriate telehealth POS (02 or 10) or the claim will reject or deny.
- "Rolling Up" Services: CCBHCs must "roll up" detail service lines at the procedure code level, despite any differences in staffing level or place of service that may occur in the delivery of one or more/multiple units. This is different than traditional Community Mental Health Center (CMHC) billings where "rolling up" occurred only when the procedure code, modifier, and place of service code all matched. If any unit of a rolled-up service was delivered via telehealth, the CCBHC must use the appropriate telehealth modifier and POS codes.
  - Example: 6 units of therapy/counseling (H0004) are provided in a single day to a single client. 4 units are provided in office and 2 units are provided over the phone to the client who is at their own home. The CCBHC should bill this as a single detail service line with the procedure code H0004, modifier 93, POS 10, and 6 units denoted.
- Billing for Methadone: For CCBHCs that have been deemed eligible to provide methadone (MAT) services and are appropriately credentialed and enrolled in IMPACT with the methadone subspecialty, the dispensing and administration of methadone is billed using detail code H0020. H0020 represents a weekly episode of care and may only be billed once every 7 days for customers receiving methadone services.

IX. 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 aged 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 need 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 SLP 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 provider--Elderly (IDoA)
092	Waiver service provider--Disability (DHS/DRS)
093	Waiver service provider--HIV/AIDS (DHS/DRS)
098	Waiver service provider--TBI (DHS/DRS)

i. Atypical Provider IMPACT Registration

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's 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

* HFS Provider Type 57 (Home Health Agency) is not a billable provider type to the MCOs. All PT 57 providers are directed to reach out to *The Division of Specialized Care for Children* (DSCC) for assistance in filing claims to this agency.

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 ***without*** an NPI. Refer to the Home Health section for billing rules to MCOs.

ii. 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.

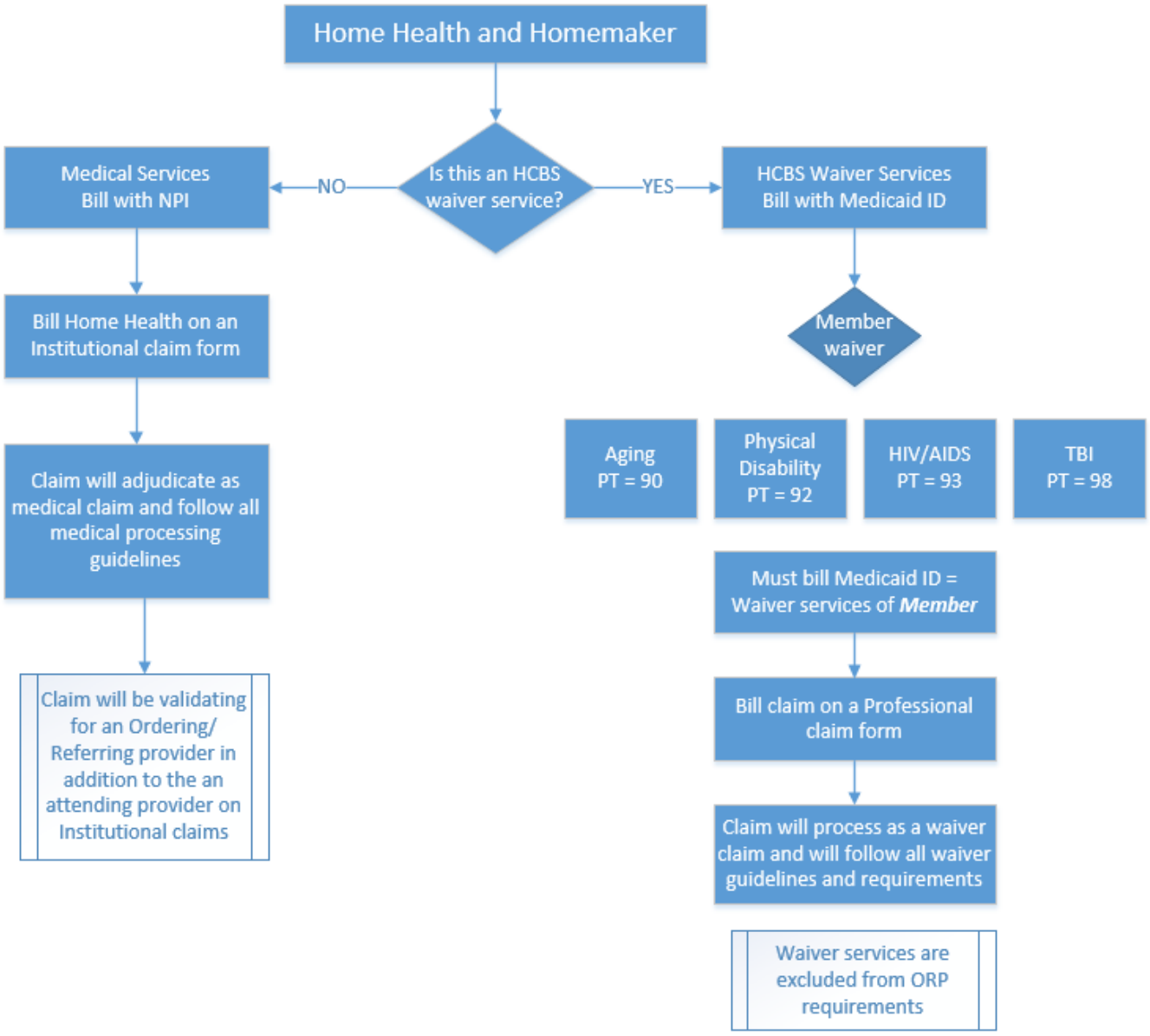
iii. Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to an 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 Provider Information Sheet provided by HFS.

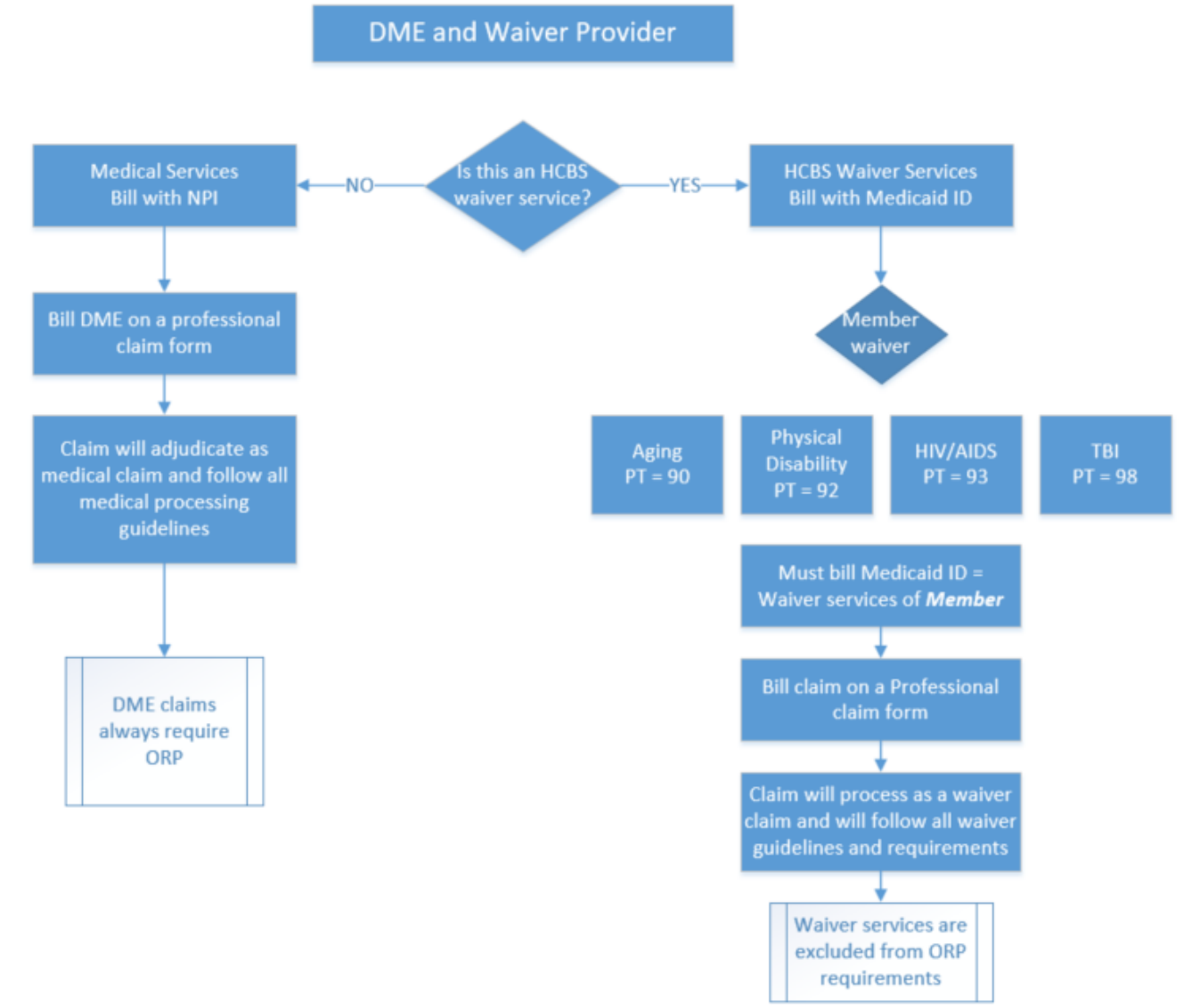
HFS Legacy Category of Service	IMPACT Subspecialty
090	Case Management
091	Home Maker
092	Agency Providers PA, RN, LPN, CAN and Therapist
093	Individual Providers PA, RN, LPN, CAN and Therapist
094	Adult Day Service
095	Habilitation Services
096	Respite care
097	Other HCFA approved services
098	Electronic 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	S5130		15 minutes 1 hour = 4 units	12	Y	Y	Y	Y	91	376J00000X--Homemaker 251E00000X--Home health
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003*		1 unit is 1 trip maximum of 2 daily	99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care

* For Aetna Better Health of Illinois, each round trip service (2 units) must be billed on a separate line for each trip date. Multiple dates of service cannot be rolled up onto one line .

Correct Billing Example:

DOS From	DOS To	POS	HCPCS	Units
7.1.22	7.1.22	99	T2003	2
7.2.22	7.2.22	99	T2003	2
7.3.22	7.3.22	99	T2003	2

Incorrect Billing Example:

DOS From	DOS To	POS	HCPCS	Units
7.1.22	7.3.22	99	T2003	6

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 Adult Day Care	T1005	HQ	15 minutes 1 hour = 4 units	99		Y	Y	Y	94	261QA0600X--Adult Day Care 385H00000X--Respite Care
Respite Adult Day Care Transportation	T1005	HB	1 unit is 1 trip maximum of 2 daily	99		Y	Y	Y	94	261QA0600X--Adult Day Care 385H00000X--Respite Care
Respite Homemaker	T1005	SE	15 minutes 1 hour = 4 units	12		Y	Y	Y	96	385H00000X--Respite Care 376J00000X--Homemaker
Agency Services RN	T1002		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
Agency Services LPN	T1003		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
Agency Services C N A	T1004		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care
Agency Services- Individualized service provided to more than one patient in the same setting **Eff. with DOS 8/1/25, this code should not be used to bill MCOs for these**	T1002	TT	15 minutes 2 hour = 8 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In 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
services. It is replaced by either G0299 or G0300.										
Effective with DOS beginning 8/1/25: Skilled Intermittent – Agency Provider RN	G0299		15 minutes 2 hour = 8 units	12		Y	Y	y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
Effective with DOS beginning 8/1/25: Skilled Intermittent – Agency Provider LPN	G0300		15 minutes 2 hour = 8 units	12		Y	Y	y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
TBI Day Habilitation	T2020		Per Diem 1 day = 1 unit	11, 99 **Eff. 8/1/25, POS 99 will no longer be accepted. Use POS 11 only**				Y	95	261QR0400X--Specialized Rehabilitation 373H00000X--Day Training Habilitation Specialist 251E00000X--Home Health
Prevocational Services	T2014		Per Diem 1 day = 1 unit	11, 99				Y	95	251S00000X--Community/Behavioral Health 251E00000X--Home Health
Supported Employment No Job Coach Individual	T2019		1 unit = 1 hour	11, 99				Y	95	251S00000X--Community/Behavioral Health 261QR0400X--Specialized Rehabilitation 251E00000X--Home Health

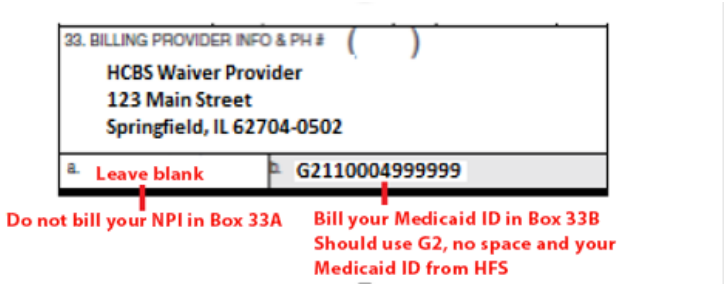
HCBS Service	HCPCS Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/ Subspecialty	Acceptable Taxonomies
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period **Eff. 7/1/2025, maximum of $26,300 in 3 year period**	12		Y	Y	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor
Specialized Medical Equipment/Supplies Purchase	T2028		Varies with services Maximum of $25,000.00 on a five-year period **Eff 7/1/25, maximum of $26,300 in 3 year period**	12, 99		Y	Y	Y	97	332B00000X--Medical Equipment & Medical Supplies
Specialized Medical Equipment/Supplies Rental	T2028	RR		12, 99		Y	Y	Y	97	332B00000X--Medical Equipment & Medical Supplies
Behavioral Services Master's Degree Level (MA)	H0004	HO	Per visit with a 2-hour maximum	11, 12				Y	97	251S00000X--Community/Behavioral Health
Behavioral Services Doctoral Level (PHD)	H0004	HP	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	Y	97	225100000X--Physical Therapist 251E00000X--Home 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
Occupational Therapy	G0152		15 minutes 1 hour = 4 units Maximum = 4 hours per day	11, 12		Y	Y	Y	97	225X00000X--Occupational Therapist 251E00000X--Home Health
Speech Therapy	G0153		Per visit with a 4-hour max	11, 12		Y	Y	Y	97	235Z00000X--Speech Therapist 251E00000X--Home Health
Speech Therapy-Services delivered under an outpatient hospital speech language pathology plan of care	G0153	GN	Per visit	11, 19, 22		Y	Y	Y	97	235Z00000X--Speech Therapist 282N00000X--General Acute Hospital
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99		Y	Y	Y	97	332U00000X--Home Delivered Meals
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161*		Per Month	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Personal Emergency Response Monthly **with fall detection**	S5161	TG	Per Month	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System

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
Automatic Medication Dispenser	A9901		Per Install	12, 99	Y				98	332B00000X--Medical Equipment & Medical Supplies
Automatic Medication Dispenser Monthly	T1505		Per Month	12, 99	Y				98	332B00000X--Medical 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 
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.*

X. 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.:

Legacy Provider Type	Taxonomy	Provider Type Description	Category of Service
22	225100000X	Physical Therapists	11, 41, 48
23	225X00000X	Occupational Therapists	12, 41, 48
24	235Z00000X	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 Outpatient Hospital billing guidance 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 HFS Fee Schedule under the crosswalk tab. MCOs require the use of the cross-walked code.

D. Services

i. Covered Services

Covered therapy services include medically necessary evaluations and treatment by a licensed therapist when:

1. services are required because an illness, disability or infirmity limits functional performance; and
2. 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.

ii. 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.

iii. 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.

XI. Dental Providers

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 in the Dental Office Reference Manual with more specific coverage details found in Exhibits A-C.

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.

MCO	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: Envolve Dental Phone: 833-522-0132 On-line Portal: https://pwp.envolvedental.com/PWP/Landing
Molina Healthcare	Vendor: DentaQuest Phone: 800-508-6780 On-line Portal: www.dentaquest.com/dentists

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.

MCO	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
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:** Envolve Dental **Portal:** https://pwp.envolvedental.com/PWP/Landing **Electronic:** Via Clearinghouse – Payer ID 46278 **Paper:** Envolve Dental P.O. Box 22377 Tampa, FL 33622-2377

MCO	Claim Submission Methods
Molina Healthcare	**Vendor:** DentaQuest **Portal**: www.dentaquest.com **Electronic:** Via Clearinghouse – Payer ID 20934 Include Address on electronic claims: DentaQuest LLC PO Box 2906 Milwaukee, WI 53201-2906 **Paper:** DentaQuest LLC PO Box 2906 Milwaukee, WI 53201-2906

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 aged 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 Pre-payment 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.

MCO	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: DentaQuest Portal: www.dentaquest.com/dentists Phone: 800-508-6780

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 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) – HFS Form 3365.

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
    - 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.

XII. Vision Providers

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).

C. 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 (e.g. 332H00000X for Opticians/Optical Companies). For further information, please refer to the Manual's Introduction, Provider Types/Category of Service/Taxonomy Codes. Taxonomy codes can be

D. Billing Requirements

i. Covered Services

Covered vision services can be located in the HFS Handbook for Optometric Services.

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.

MCO	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
Meridian	Meridian Network (Non-Delegated) Phone: 800-654-2833 JAK Laboratories https://www.jakopticallaboratories.com/

MCO	Vision Vendor
Molina Healthcare	Avēsis Phone: 866-337-1596 www.avesis.com Provider Portal: https://www.avesis.com/commercial3/providers/index.aspx

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: Meridian does 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.

MCO	Vision Claim Submission Methods
Aetna Better Health® of Illinois	**Vendor:** MARCH® Vision Care **Portal:** https://providers.eyesynergy.com/Home/Landing?ReturnUrl=%2f **Electronic:** Payor ID for Optum is 52461 **Paper:** 6601 Center Drive West, Suite 200 Los Angeles, CA 90045
Blue Cross Community Health Plan (BCCHP)	**Claims PRIOR to DOS 4/1/22** **Vendor:** Davis Vision **Portal:** Provider Portal: https://davisvision.com/eye-care-professionals/ **Electronic:** V0QJA 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** **Vendor**: Heritage Vision - Powered by VSP ® **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
CountyCare Health Plan	**Vendor:** Avēsis **Portal:** https://www.avesis.com/commercial3/providers/index.aspx **Electronic:** Via Clearinghouse – Payer ID 86098 **Paper:** Avēsis Third Party Administrators, Inc. PO Box 38300 Phoenix, AZ 85069-8300
Meridian	**Vendor:** Please direct claims to Meridian Plan **Secure Provider Portal:** Click Here **Electronic:** Via Clearinghouse – Payer ID MHPIL **Paper**: Meridian PO Box 4020 Farmington, MO 63640-4402
Molina Healthcare	**Vendor:** Avēsis **Portal:** https://www.avesis.com/commercial3/providers/index.aspx **Electronic:** Via Clearinghouse – Payer ID 86098 **Paper:** Avēsis Third Party Administrators, Inc. PO Box 38300 Phoenix, AZ 85069-8300

E. 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, refer to the General Claim Submission Guidelines for All Providers/Prior Authorization Section of the manual.

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.

XIII. 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 all 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.

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 below.
- Categories of Service (COS) and Specialties: Although COS is not directly added to a claim submitted to an 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 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. For transportation, see Table below.

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
Transportation Network company (effective 11/1/2023)	73	141	347C00000X
Private Automobile	73	55	347C00000X

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

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, transportation network cars (e.g. Uber/Lyft), 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

	Type of Service	Description	Type of Provider	HCPCS Code	Modifier
Non-Emergent Non- Ambulance	Mileage	Private Auto – Per Trip Mileage (No Base Rate Allowed	Non-Ambulance	A0090	
	Base Rate	Taxi	Non-Ambulance	A0100	
	Base Rate	Service Car	Non-Ambulance	A0120	
	Base Rate	Medicar (Wheel Chair Van)	Non-Ambulance	A0130	
	Mileage	Taxi, Service Car, Medicar, Stretcher Van	As Applicable	A0425	
	Attendant	Attendant	Non-Ambulance	T2001	
	Attendant	Attendant (additional attendant)	Non-Ambulance	T2001	TK
	Encounter/Trip	Transportation Network Provider Trip	Non-Ambulance	T2003	
	Stretcher Van	Stretcher Van	Non-Ambulance	T2005	
Non-Emergent Behavioral Health Transport	Base Rate	Ambulance, any type	Ambulance	A0999	
	Mileage	BLS Mileage	Ambulance	A0380	
	Base Rate	Safety Care	As Appropriate	A0110	
	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

Transport Type	Reimbursable Services
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

** "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).
  - 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, Medicar 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: 833-728-0122
Molina Healthcare	**Electronic Claim Submission** A PCS and CTS 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. **mtm-inc.net/healthcare-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 Online Portal or with the paper claim.

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 non-emergency 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 – N - Skilled nursing 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.

MCO	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	ModivCare	Danyel Ziegel Mark Sowerby (claims)	800-530-9060	phxopsspecialist@modivcare.com support.claims@modivcare.com
Meridian	MTM	Duane Williams Eric Johns		dwilliams@mtm-inc.net eric.johns@mhplan.com
Molina Healthcare	MTM	Daisy Roman	630-381-8890	daisy.roman@molinahealthcare.com

XIV. 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 Orthotic, Prosthetic and Pedorthic Services, 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 DME fee schedule. The fee schedule and corresponding key 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 General Claim Submission for all Providers 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

XV. 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.

i. NPIs

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

ii. Categories of Service

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

iii. Taxonomies

335E00000X or 332B00000X

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.

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 DME/OPP fee schedule. 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 one 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
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

XVI. Diabetes Prevention Program (DPP) and Diabetes Self-Management and Education (DSMES) 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 **new** 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):

Enrollment Type	Provider Type	Specialty	Sub-Specialty	Taxonomy Code	Legacy PT	Legacy COS
Facility, Agency, Organization (FAO)	Diabetes Prevention Provider Organization	Diabetes Prevention Provider Organization	No Subspecialty	174H00000X	102	124
Facility, Agency, Organization (FAO)	Diabetes Self-Management, Education and Support Organization	Diabetes Self-Management, Education and Support Organization	No Subspecialty	174H00000X	103	125

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 provided other than in patient's home	13 – Assisted Living Facility
03 – School-based Clinics	14 – Group Home
04 – Homeless Shelter	19 – Outpatient Hospital-Off Campus
10 – Telehealth provided in patient's home* **eff. with DOS beginning 7/1/2022**	22 – Outpatient Hospital-On Campus
11 – Office	27 – Outreach Site/Street (effective 10/1/23)
12 – Home	99 – Other Place of Service (community-based setting)

** Telehealth services (POS 02 or 10) must include either the modifier GT (services delivered via audio and video) or 93 (services delivered via audio only [**eff. with DOS beginning 7/1/2022**])*

C. Billing and Coding

i. DPP Services

a) Eligibility for Services

Members are eligible for DPP services if they:

- are over the age of 18 ***(NOTE: for dates of service prior to 11/1/24, eligibility was limited to members between the ages of 18 and 64);***
- are overweight or obese (BMI of ≥ 25 kg/m2 or ≥ 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 - 1st core session attended	GT or 93	none
Milestone 2	G9874 – 4 total core sessions attended	GT or 93	VM
Milestone 3	G9875 – 9 core sessions attended	GT or 93	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 or 93	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 or 93	VM
Performance:	G9880 – 5% weight loss from baseline achieved	GT or 93	none

** All codes can only be billed once in a 365-day time period*

*** Telehealth services (POS 02 or 10) must include either the modifier GT (services delivered via audio and video) or 93 (services delivered via audio only [**eff. with DOS beginning 7/1/2022**]). If both modifiers are used (i.e.,VM), GT or 93 must be the first one listed*

c) 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 **subsequent** claim, DPP providers only need to provide only the R or Z code used on the initial 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.

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 over the age of 18 with documentation of a diagnosis of type 1, type 2 or gestational diabetes ***(NOTE: for dates of service prior to 11/1/24, eligibility was limited to members between the ages of 18 and 64);***

- 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	Virtual/Telehealth Modifier*	Limitation
Individual Outpatient DSMES	G0108 Diabetes outpatient self-mgt training services, individual	30 minutes	GT or 93	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	GT or 93	30 units (15 hours) in 12 mo. period

** Telehealth services (POS 02 or 10) must include either the modifier GT (services delivered via audio and video) or 93 (services delivered via audio only **[eff. with DOS beginning 7/1/2022]**)*

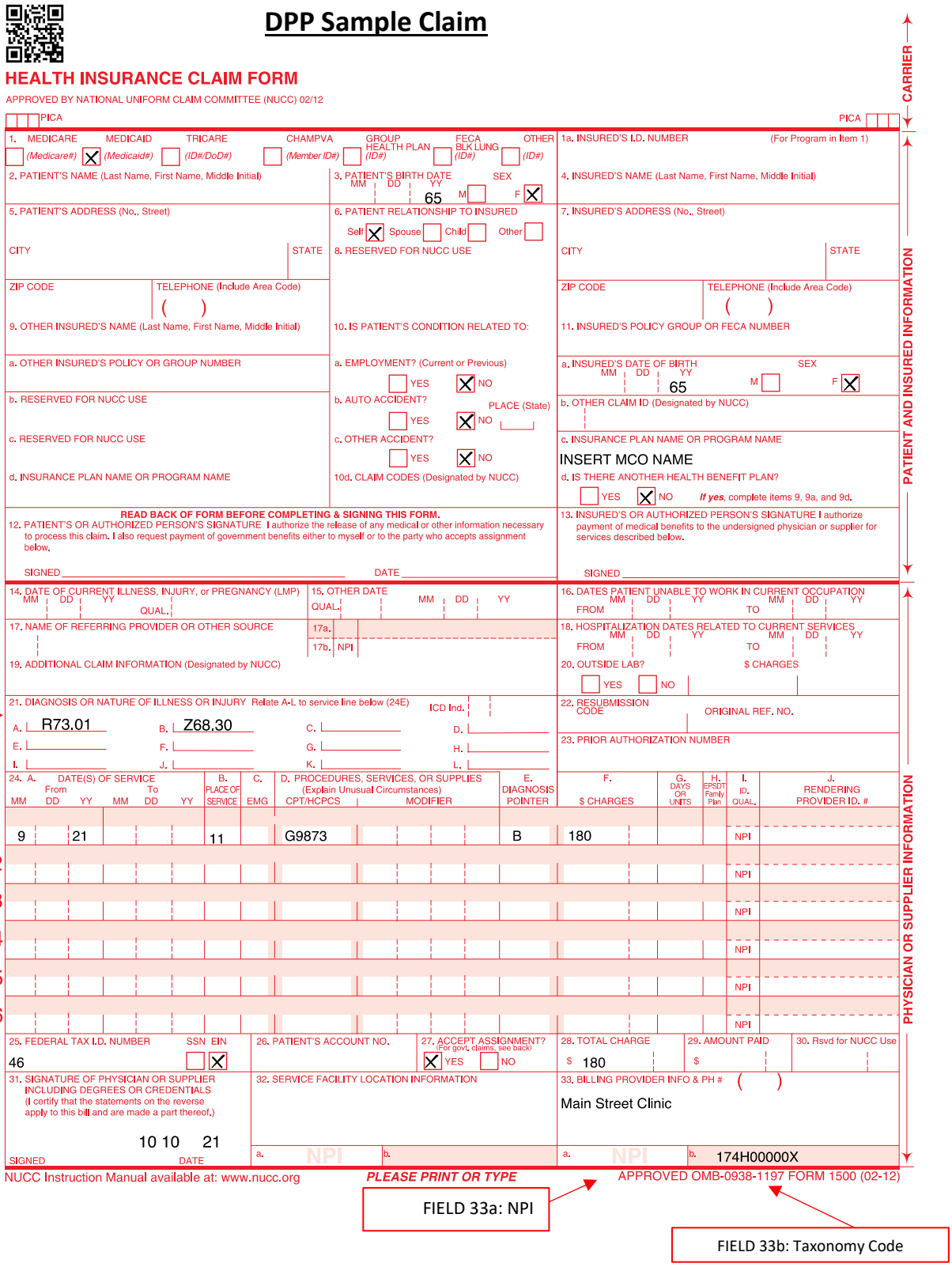
The following diagnosis codes are to be used for billing on the **initial** claim for services:

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY 65 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

ZIP CODE | TELEPHONE (Include Area Code) ( )

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY 65 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME INSERT MCO NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. R73.01 B. Z68.30 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 9 21		11		G9873		B	180			NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X] 46

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 180

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED 10 10 21 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Main Street Clinic

a. NPI b. 174H00000X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FIELD 21: Dx Code(s)

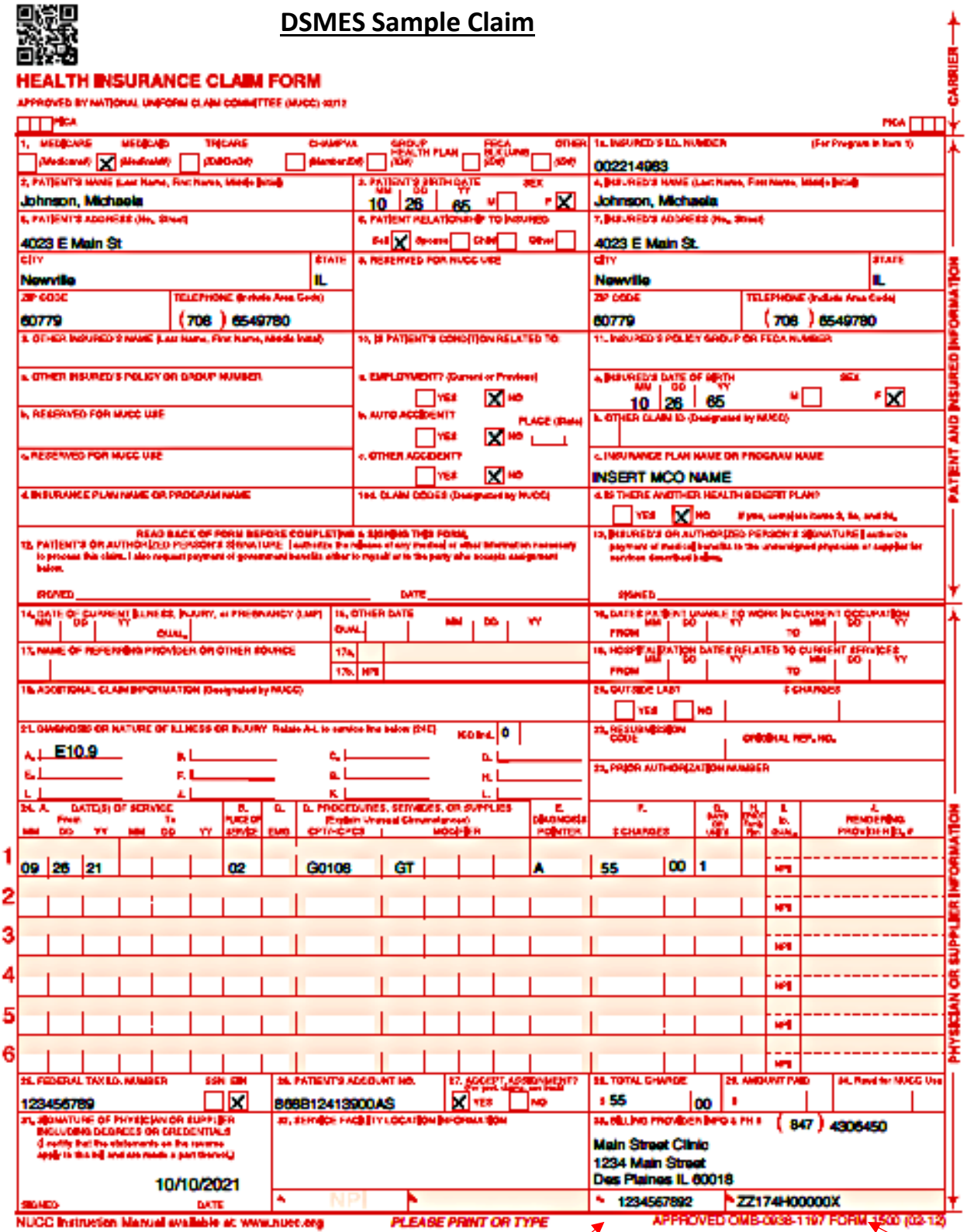
FIELD 24B: POS Code
FIELD 24D: HCPCS Code

FIELD 25: TIN

FIELD 33a: NPI

FIELD 33b: Taxonomy Code

DSMES Sample Claim



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER | PICA

1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐ — 1a. INSURED'S I.D. NUMBER: 002214983

2. PATIENT'S NAME: Johnson, Michaela

3. PATIENT'S BIRTH DATE: 10 26 65 — SEX: M ☐ F ☒

4. INSURED'S NAME: Johnson, Michaela

5. PATIENT'S ADDRESS: 4023 E Main St

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS: 4023 E Main St.

CITY: Nowville — STATE: IL

8. RESERVED FOR NUCC USE

CITY: Nowville — STATE: IL

ZIP CODE: 60779 — TELEPHONE: (708) 6549780

ZIP CODE: 60779 — TELEPHONE: (708) 6549780

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

4a. INSURED'S DATE OF BIRTH: 10 26 65 — SEX: M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: INSERT MCO NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY — QUAL.

15. OTHER DATE MM DD YY — QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) — ICD Ind. 0

A. E10.9 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09	26	21			02		G0108	GT	A	55 00	1		NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 123456789 — SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 868812413900AS

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 55 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 10/10/2021 — SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI

33. BILLING PROVIDER INFO & PH #: (847) 4306450

Main Street Clinic
1234 Main Street
Des Plaines IL 60018

a. 1234567892 — b. ZZ174H00000X

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

FIELD 25: TIN

FIELD 33a: NPI

FIELD 33b: Taxonomy Code

XVII. Acupuncture Services

A. Purpose

The purpose of this section is to outline the billing policies and procedures for acupuncture providers.

B. Provider Type

i. IMPACT registration

Acupuncturists must be licensed, have an NPI and be enrolled in the IMPACT enrollment system according to the table below.

Enrollment Type	Provider Type	Specialty	Sub-Specialty	Taxonomy Code	Legacy PT	Legacy COS
Individual/Sole Proprietor	Acupuncturist	Acupuncturist	No Subspecialty	171100000X	106	130
			Primary Specialty			

C. Coding Guidance

i. Allowable Billing Codes

Acupuncture services are eligible for reimbursement effective with dates of service starting on 4/1/2023. Claims should be submitted using the 837P or CMS-1500 claim format. Allowable procedure codes with their daily maximum units can be found in the table below. The HFS Acupuncture Fee Schedule can be found here.

Procedure Code	Description	Daily Max Unit Qty
97810	Acupuncture, 1 or more needles ; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	1
97811	Acupuncture, 1 or more needles ; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	2
97813	Acupuncture, 1 or more needles ; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	1
97814	Acupuncture, 1 or more needles ; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	2

When billing as solo practitioner, the acupuncturist's NPI and taxonomy information should be listed in the Billing Provider loop when submitted electronically (837P) or the Billing Provider data fields when submitted on a paper claim (CMS-155). It is not required to be listed in the Rendering Provider loops/fields as well. If the acupuncturist is employed by a group practice or clinic, the group practice's information (NPI, taxonomy) would go in the Billing Provider loops/fields, and the acupuncturist's information in the Rendering Provider loops/fields.

ii. Medical Necessity Requirements

Coverage of acupuncture services is limited to treatment of specific diagnoses relating to chronic low back pain and breech baby presentation. Claims will only be processed and paid with at least one of the diagnosis codes listed on the second tab of the HFS Acupuncture Fee Schedule (open using the xlxs link to access the second tab).

XVIII. Genetic Counseling Services

A. Purpose

The purpose of this section is to outline the provider enrollment and billing guidelines for licensed genetic counselors.

B. Provider Type

i. IMPACT Registration

Effective with dates of service starting on April 1, 2024, genetic counselors licensed under 68 Ill. Admin. Code Part 1251 may enroll and bill for Medicaid services. Genetic counselors must obtain an NPI and enroll in the IMPACT system as either:

1. Rendering/Servicing Provider – An individual provider who will be rendering services to MCO members, but will not be submitting claims directly to the MCO (i.e. a group practice or clinic will be submitting them on their behalf. Enrolling as a Rendering Provider **requires** associating with a Group Practice or Facility, Agency, Organization (FAO) as a billing provider in the IMPACT system. Providers enrolled as Rendering/Servicing providers will not be allowed to bill on their own behalf.
2. Individual/Sole Proprietor – This is a provider that owns his/her own practice. Sole Proprietors may receive payments directly or associate to Billing Providers and/or Billing Agents. If enrolled as a Sole Proprietor, providers can still **also** associate with a Group Practice or FAO as their Billing Provider(s) to bill on their behalf, but are not required to do so. Providers should use this enrollment type when they plan to work as part of an organization and/or work and bill as an independent practitioner.

Licensed Genetic Counselors IMPACT Enrollment					
IMPACT Provider Type	Specialty	Subspecialty	Taxonomy	Legacy PT	Legacy COS
Genetic Counselor	Genetic Counseling Services	No Subspecialty	170300000X	112	144

C. Coding Guidance

i. Allowable Billing Codes

Genetic counselors may bill for reimbursement with dates of service starting on 4/1/2024. Genetic counseling services do not require a referring provider.

Procedure Code	Description	Maximum Units
96041	Medical genetics and genetic counseling services, each 30 minutes of face-to-face time with patient/family	4

Services may be provided via telehealth using modifier GT (via audio and video) or 93 (via telephone or other real-time interactive audio-only) and place of service 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home), as applicable.

Previously physicians would bill 96040 on behalf of a licensed genetic counselor. This code will now be billable only by licensed genetic counselors. Physicians providing these services must use the appropriate Evaluation and Management procedure codes, following CPT guidelines. **To accommodate this billing transition, physicians may continue to bill 96040 on behalf of a licensed genetic counselor until their associated genetic counselor is enrolled, but no later than February 1, 2025.**

XIX. Doulas and Lactation Consultants

A. Purpose

The purpose of this section is to outline the provider enrollment and billing guidelines for doulas and lactation consultants. Doula services are effective as of February 1, 2024 and lactation consultant services are effective as of January 1, 2024.

B. Provider Type

i. Required Certifications

Prior to enrolling in IMPACT, the following certifications must be obtained:

Provider Type	Certifying Body
Doula	Illinois Medicaid-certified Doula Program (administered by the SIU School of Medicine)
International Board-Certified Lactation Consultant (IBCLC)	International Board of Lactation Consultant Examiners
Certified Lactation Counselors (CLC)	Academy of Lactation Policy and Practice, Inc.
Certified Lactation Specialists (CLS)	Lactation Education Consultants

Certificates issued must have a unique certification number tied to the provider, with an effective date and expiration date. The certificate must be uploaded during the IMPACT enrollment process.

Doulas and lactation consultants must also obtain a National Provider Identifier (NPI) number in order to complete IMPACT enrollment.

ii. IMPACT Enrollment

In IMPACT, doulas and lactation consultants will select an Enrollment Type of either:

1. **Rendering/Servicing Provider** – An individual provider who will be rendering services to Medicaid members but will not be submitting claims directly to the MCOs. Enrolling as a Rendering provider **requires** that the provider associate with a Group Practice or Facility, Agency, Organization (FAO) as a billing provider in the IMPACT system. Rendering/Servicing Providers cannot bill/submit claims on their behalf.
2. **Regular Individual Sole Proprietor** – A provider that owns his/her own practice. A Sole Proprietor may submit claims and receive payments directly or can associate to Billing Providers and/or Billing Agents. Sole Proprietors can still **also** associate with a Group Practice or FAO as their Billing Provider(s) to bill on their behalf, but this is optional. Providers should use this enrollment option if they plan to work as part of an organization and/or bill for themselves.

Providers should enroll according to the table below.

IMPACT Provider Type	IMPACT Specialty	IMPACT Subspecialty	Legacy PT	Legacy COS	Taxonomy Code
Health Support Professional	Doula	No Subspecialty Primary Subspecialty	111	145	374J00000X
Health Support Professional	Lactation Consultants	International Board-Certified Lactation Consultant (IBCLC)	111	142	174N00000X
Health Support Professional	Lactation Consultants	Lactation Support Professional (LSP) [includes Certified Lactation Counselors and Certified Lactation Specialists]	111	143	174N00000X

Note: Advanced Practice Nurses who are also certified as a doula or an IBCLC, CLC or CLS do not need to enroll under this new provider type. APNs are able to bill using the Evaluation and Management codes from the Practitioner Fee Schedule

Further support and training on IMPACT enrollment for doulas and lactation consultants can be accessed from the Medicaid Technical Assistance Center (MTAC).

C. Coding Guidance

Doula and lactation consultant services are to be billed using the CMS-1500 or 837P professional claim format. For allowable services provided via telehealth, claims must include Place of Service 10 (patient's home) or 02 (telehealth provided other than in patient's home), and the modifier GT (audio and video service) or modifier 93 (audio only service). Services allowed to be delivered by telehealth are indicated in the procedure code tables found below.

i. Standing Recommendations

The State of Illinois has issued standing recommendations for both doula and lactation consultant services. When these services are delivered, doulas and/or lactation consultants must note in their service documentation that they either 1) used the State's standing recommendation; or 2) used a recommendation from a specific licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN). This documentation is required for audit purposes and to meet federal requirements that services be recommended by a licensed provider. The information is not included on submitted claims.

The State of Illinois standing recommendation cannot be used by IBCLCs, CLCs, or CLSs if breastfeeding is contraindicated by any drug use or health condition, as specified in the standing recommendation.

ii. Billable Codes – Doulas

The following are the allowable doula procedure codes. More detail regarding the billable procedures is contained in the HFS Doula Fee Schedule.

Procedure Code	Description	Telehealth Allowed
S9445	Non-physician prenatal patient education – billable in 15 min increments per unit	√
59409	Labor and Delivery Support – vaginal delivery only	
59514	Labor and Delivery Support – cesarean delivery	
59612	Labor and Delivery Support – vaginal delivery, after previous cesarean delivery (VBAC)	
59620	Labor and Delivery Support – cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	
S9444	Postpartum parenting education, advocacy and connection to appropriate resources – billable in 15 min increments per unit	√
59430*	Postpartum visit (attendance with birthing person at practitioner/OB visit)	
99381	Initial newborn visit – facilitation and attendance (1st newborn visit with practitioner that occurs within 2 weeks of delivery)	
T1032	Doula support during or after miscarriage or abortion – billable in 15 min increments per unit	√

* CPT code 59430 is reimbursable only when the doula attends the postpartum visit with a practitioner, and the visit occurs within 26 days from the delivery date, and/or between 27-89 days of the delivery date. The actual delivery date must be reported on the claim to receive payment (provided the above timelines are met).

NOTE: Federally Qualified Health Centers, Rural Health Clinics, and Encounter Rate Clinics will be allowed to bill fee for service claims. For the services listed above, the service must be billed under the enrolled, rendering doula's NPI with payment directed to the clinic/center's corporate NPI.

iii. Billable Codes – Lactation Consultants

The following are the allowable lactation consultant procedure codes. Lactation consultant services must be billed under the birthing person's Medicaid Recipient Identification Number (RIN), or the child's RIN if the birthing person is not Medicaid eligible. More detail regarding billable procedures is contained in the HFS Lactation Consultant Fee Schedule.

Procedure Code	Modifier	Description	Telehealth Allowed
S9443	HD (pregnant/parenting women's program	Lactation consultation service by International Board-certified Lactation Consultant (IBCLC)	√
S9443	No modifier	Lactation consultation service by Certified Lactation Counselor (CLC) or Certified Lactation Specialist (CLS)	√
S9443	HD HQ (group services)	Group lactation consultation service by International Board-certified Lactation Consultant (IBCLC) (2+ members)	√
S9443	HQ (group services)	Group lactation consultation service by Certified Lactation Counselor (CLC) or Certified Lactation Specialist (CLS) (2+ members)	√

NOTE: Federally Qualified Health Centers, Rural Health Clinics, and Encounter Rate Clinics will be allowed to bill fee for service claims. For the services listed above, the service must be billed under the enrolled, rendering lactation consultant's NPI with payment directed to the clinic/center's corporate NPI.

Appendix A: List of HFS Registered Children's Hospitals

Medicaid ID	NPI	Hospital Name
370723793006	XXXX941105	Abraham Lincoln Children's Hospital
364251846002	XXXX581725	Alexian Bros Children's Hospital
430738490001	XXXX935891	Cardinal Glennon Children's Hospital
390812532001	XXXX482022	Children's Hosp of Wisconsin
370662569009	XXXX734127	Children's Hospital of Illinois
363488183008	XXXX894990	Comer Children's Hospital
362169147027	XXXX375082	Hope Children's Hospital
362170866002	XXXX387388	Ingalls Children's Hospital
362170143001	XXXX146430	La Rabida Children's Hosp
362170833007	XXXX234535	Lurie Children's Hospital
362169147026	XXXX539730	Lutheran General Children's Hospital
370661220012	XXXX099098	Memorial Med Ctr Children's Hospital
370661230003	XXXX861330	Passavant Area Children's Hospital
430666765002	XXXX117532	Ranken Jordan A Ped Rehab Center
364015560005	XXXX361748	Ronald Mcdonalds Children's Hospital
362174823005	XXXX908728	Rush Children's Services
362193608002	XXXX656538	Shriners Hospital for Children
362193608001	XXXX343447	Shriners Hospital for Children
361509000006	XXXX733681	Sinai Children's Hospital
370661238009	XXXX637591	St Johns Children's Hospital
430654870001	XXXX727663	St Louis Children's Hospital
370661250009	XXXX729036	Taylorville Mem Children's Hospital

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 HFS:
https://iamhp.net/resources/Pictures/General%20Acute%20Care%20and%20Children's%20Hospitals%20Billing%20Guidelines%20-%20IAMHP%20Provider%20Memo.pdf

HFS:
https://www.illinois.gov/hfs/SiteCollectionDocuments/110316ErrorCodes.xlsx

Error Code	Message	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 Taxonomy 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 1-877-782-5565.

2

Detailed Example Describing Billing Scenario

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.

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)
- ~~Labor and Delivery Claim~~ 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)

Existing IAMHP Guidance since 2016 has stated verbiage generically listed as 'Labor and Delivery' 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

2

Use Case

Sample State of Illinois Provider System Examples that share HFS' 'Childrens Hospital' Designation and 'General Acute' Designation

HFS Registered Childrens Hospitals		
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

Example Data from the HFS Provider Data Sent to the MCOs (MAP File)

HFS Medicaid ID	HFS associated NPI	HFS Provider Name	HFS Provider Street Address	HFS Provider City	HFS State	HFS Provider Zip First 5	HFS Provider Type	HFS COS	HFS COS	HFS COS	Eligibility Begin date for HFS COS	Eligibility End date for HFS COS	Enrollment Begin Date CYD	Enrollment End Begin Date CYD
Rush System Hospital Example														
362174823017	1326140583	RUSH UNIVERSITY MEDICAL CENTER	1653 W CONGRESS PKWY	CHICAGO	IL	60612	030	021	021	022	2004122	9999999	2004122	9999999
362174823005	1801908728	RUSH CHILDRENS SERVICES	1753 W CONGRESS PKWY	CHICAGO	IL	60612	030	021			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 Conegress 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 anc 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

3

Appendix C: ICD-9 to ICD 10 Crosswalk for Hospitals with General Acute and HFS defined Children's Hospital

ICD9 Diagnosis Code Range	Equivalent ICD10 Diagnosis Code Range						
290-302	F03xx F05xx F01xx F10xx F19xx F15xx F11xx F14xx	F13xx F12xx F16xx F17xx F18xx F05 F06xx F53	F04 F02xx F20xx F2xx F30xx F39 F33xx F31xx	F22 F23 F24 F28 F3xx F44xx F8xx F4xx	F68xx F6xx F40xx F45xx F99 F60xx F21 F66	Z87xx R37 F5xx F52xx F65xx	
306	F45xx F52xx F59						
630 – 677	O019 O0281 O021 O0xx O03xx O04xx Z3xx O07xx O08xx	O2xx O44xx O45xx O46xx O6xx O10xx O1xx O14xx O15xx	O60xx O47xx O4xx O31xx O12xx O26xx O90xx O23xx O86xx	O99xx O98xx O24xx O9xx O3xx O25xx O9Axx O75xx O80	O30xx O32xx O33xx O34xx O35xx O36xx O43xx O68 O7xx	O40xx O41xx O42xx O09xx O76 O64xx O66xx O69xx O71xx	O89xx O8xx O82 O85 O22xx O88xx O91xx 92xx O94
V22	Z33xx Z34xx						
V23	O09XX O092XX O095XX O096XX O098XX						
V28	Z36						

Appendix D: MCO Sample EOPs

Aetna Better Health of Illinois	Pages D-2 to D-3
Blue Cross Community Health Plans	Pages D-4 to D-6
County Care Health Plan	Pages D-7 to D-8
MeridianHealth	Pages D-9 to D-11
Molina HealthCare	Pages D-12 to D-15

P779902800F

aetna™

Aetna Better Health of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

Return Service Requested

WHITE STOCK
20201123012 9
CGBY

SINGLE PIECE
1 0.730 SP 0.500
XXXXXXXX XXXXXXXX XXXX
PO BOX XXXXXX
LOS ANGELES, CA XXXXX-XXXX
1

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

1 OF 3 F
ENV 1

Remit Date:	09/25/2020
Beginning Balance:	0.00
Processed Amount:	000.00
Discount/Interest:	0.00
Net Amount:	000.00
Refund Amount:	0.00
Amount Recouped:	0.00
Amount Paid:	000.00
Ending Balance:	0.00
Check #:	EFT100297
Check Amount:	000.00
Bank Account:	XXXXXXXXXXXXX

XXXXX XXXXX XXXXXXXXXX
T IN: XXXXXXXX
NPI: XXXXXXXX

Benefit Plan: Aetna Better Health of Illinois

Patient: XXXX XXXX X
Member ID: XXXXXXXX
Date of Birth: 01/01/1994
Final DRG:
Place of Service: 12
Patient Acct #: XXXXXXX
Authorization ID: XXXXXXXXXX
Provider: XXXXXXX XXXXXX XXXXXX
Severity of Illness:
Claim Status: PAID
Claim#: XXXXXXXXX
Refund Amount: 0.00
Received Date: 20200812

Line	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Unit	Billed Amount	Disallowed	Allowable Amount	Patient Responsibility Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Interest	Net 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	000.00
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
						Claim Totals	246.00	0.00	219.84	0.00	0.00	0.00	0.00	219.84	0.00	000.00

Code/Description

Line 2 4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
Line 4 151 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY/FREQUENCY OF SERVICES

Patient: XXXXXXXXXXXXXXXXXXXX
Member ID:
Date of Birth: //
Final DRG:
Place of Service: 12
Patient Acct #: XXXXXXXXXXXXX
Authorization ID:
Provider: XXXXXXXXXXXXXXXXXXXX
Severity of Illness:
Claim Status: PAID
Claim#: XXXXXXXXXX
Refund Amount: 0.00
Received Date: 20200812

Line	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Unit	Billed Amount	Disallowed	Allowable Amount	Patient Responsibility Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Interest	Net Amount
2	07/09/20	B4088			FFS	1	210.00	0.00	127.56	0.00	0.00	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
						Claim Totals	584.70	0.00	137.63	0.00	0.00	0.00	0.00	137.63	0.00	000.00

Code/Description

Line 1 4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
Line 4 151 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY/FREQUENCY OF SERVICES

Patient: NIDO, ALONZO C
Member ID: 215225481
Date of Birth: 06/04/1983
Final DRG:
Place of Service: 12
Patient Acct #: 3538550500A
Authorization ID:
Provider: SHIELD DENVER HLT CARE CTR INC
Severity of Illness:
Claim Status: PAID
Claim#: 100000209727
Refund Amount: 0.00
Received Date: 20200812

VOID

Line	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Unit	Billed Amount	Disallowed	Allowable Amount	Patient Responsibility Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Interest	Net 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

P7799/2800F

20201230129

aetna™

Aetna Better Health of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

XXXXX XXXXXX XXXXXX XXXXX

T IN: XXXXXXXXXX
NPI: XXXXXXXX

WHITE STOCK

GEST

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

Remit Date: 09/25/2020
Check #: EFT100297
Benefit Plan: Aetna Better Health of Illinois

2 OF 3 F

ENV 1

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 Aetna 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:

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).

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

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.

7) 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

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

VOID

BlueCross BlueShield of Illinois

Servicing Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXX

Payee Name: XXXXXXXXXXXXXXXXXXXXXXXXXX

Servicing Provider NPI: 9999999999999

Patient and Services Information

Account Number 99999999999 **Subscriber #** 999999999 Plan Name: XXXXXXXXXXXXXX

Patient Name XXXXXXXXXXXXXXXX **Claim Id** XXXXXXXXX

Dates of Service		Proc/Rev Code	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Interest Owed	Plan Payment	Remarks
							Co Pay	Co Ins	Ded Amt	Non Cvrd			
mm/dd/yy	mm/dd/yy	XXXX	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	XXX
mm/dd/yy	mm/dd/yy	XXXX	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	XXX
Claim totals:	17276M000200		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.

BlueCross BlueShield of Illinois

	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Interest Owed	Plan Payment
					Co Pay	Co Ins	Ded Amt	Non Cvrd		
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

XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX

Payment Summary

Payment Date:	mm/dd/yy	**Total Charged:**	999,999.99
Check # :	999999999	**Total Cons Charged [1] :**	999,999.99
Paid To:	XXXXXXXXXXXXX	**Total Denied:**	999,999.99
Tax ID:	999999999	**Total Allowed:**	999,999.99
Reference Id:	XXXXXXXXXX	**Non Paid [2] :**	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
		Other Recoveries:	999,999.99
		Net Check Amount:	999,999.99

Explanation of Claims Handling

XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Payment Reduction and Recovery Summary:

Previous Balance		Recoveries on this Remittance		Reductions on this Remittance		New Balance
99,999.99	-	99,999.99	+	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 Dates of Service: mm/dd/yy- mm/dd/yy Patient Account #: XXXXXXXXXXXX Original Claim Control #: XXXXXXXX Original Check #: XXXXX Original Check Date: mm/dd/yy LOB: XXXXXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXXX Dates of Service: mm/dd/yy- mm/dd/yy Patient Account #: XXXXXXXXXXXXX Original Claim Control #: XXXXXXXX Original Check #: 99999 Original Check Date: mm/dd/yy LOB: XXXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
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.

CountyCare Health Plan
PO Box 211592
Eagan MN 55121-2892

EXPLANATION OF PAYMENT

Payment Date:	**01/16/2019**
Payee ID:	1111111111
Tax ID:	3111111111
Check Number:	**0008213690**
Claim Count:	**1**
Total Charges:	**$796.90**
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

0000493 01 MB 0.421 **AUTO T3 0 1067 60090-045757-C08-P00000-I 234

ABC HOSPITAL
123 ANY STREET
PHILADELPHIA PA 19103

Get Paid Faster! Register for ERA/EFT at https://register.instamed.com/eraeft and enter Registration Code: WUHL69

PROVIDER CLAIM SUMMARY

Dates of Service From	To	Procedure	No. of Units	Amount Billed	Allowed	Paid	Adjustments	COB	Not Covered	Withhold	Adjustment Reason	Remarks
Patient: 1333333333 SMITH JOHN				Provider: 111111111 ABC HOSPITAL					Member: 133333333 SMITH JOHN			
Interest:				Claim ID: 2018353C1233800					Patient Account Number: ABCD-11-222-3			
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

Code	Description
CO-59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)

Remarks Codes

Code	Description

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

11-24/1210

No. 0008213690
01/16/19

ONE HUNDRED EIGHTY and 15/100

VOID VOID VOID

Void after 180 days

$180.15

PAY TO THE ORDER OF
ABC HOSPITAL
123 ANY STREET
PHILADELPHIA PA 19103

0001374906 XXXXXXXXXXX XXXXXXXXX

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#: [redacted]

Insured: [redacted] Insured Id: [redacted] Patient Account #: [redacted]
Claim #: [redacted] Provider/Practitioner: [redacted]

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	23.40
Refund Amount	0.00
Refund Check #	

Insured: [redacted] Insured Id: [redacted] Patient Account #: [redacted]
Claim #: [redacted] Provider/Practitioner: [redacted]

Dates of Service	Proc Code	Billed	Provider Adjust Amt	Not Covered	Allowed	Other Carrier	Deductible	Co-Pay	Co-Ins	Net Amount	Comment Codes
02/08/2019	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	23.40
Refund Amount	0.00
Refund Check #	

Insured: [redacted] Insured Id: [redacted] Patient Account #: [redacted]
Claim #: [redacted] Provider/Practitioner: [redacted]

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	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	23.40
Refund Amount	0.00
Refund Check #	

Insured: [redacted] Insured Id: [redacted] Patient Account #: [redacted]
Claim #: [redacted] Provider/Practitioner: [redacted]

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	23.40
Refund Amount	0.00
Refund Check #	

P6590028000

Meridian Health Plan
1 Campus Martius
Suite 720
Detroit, MI 48226

20190301010O

Meridian Health Plan
CLAIMS DEPARTMENT
800-203-8206

Return Service Requested

Pre-Release

1st Class USPS Mail #10

[redacted]

1

ENV 1 1 OF 2 F

Date Processed: 02/27/2019
Check #: 0
Check Amount: 206.11
Alt ID#: [redacted]

Insured: [redacted] **Insured Id:** [redacted] **Patient Account #:** [redacted]
Claim #: [redacted] **Provider/Practitioner:** [redacted]

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	23.40
Refund Amount	0.00
Refund Check #	

Insured: [redacted] **Insured Id:** [redacted] **Patient Account #:** [redacted]
Claim #: [redacted] **Provider/Practitioner:** [redacted]

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	23.40
Refund Amount	0.00
Refund Check #	

Insured: [redacted] **Insured Id:** [redacted] **Patient Account #:** [redacted]
Claim #: [redacted] **Provider/Practitioner:** [redacted]

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	23.40
Refund Amount	0.00
Refund Check #	

Insured: [redacted] **Insured Id:** [redacted] **Patient Account #:** [redacted]
Claim #: [redacted] **Provider/Practitioner:** [redacted]

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	

Interest Amount	0.00
Total Claim Amount	18.91
Refund Amount	0.00
Refund Check #	

P6590028000

20190301010100

Meridian Health Plan
1 Campus Martius
Suite 720
Detroit, MI 48226

Meridian Health Plan
CLAIMS DEPARTMENT
800-203-8206

[redacted]

ENV 1 2 OF 2 F

Pre-Release Preview

Date Processed: 02/27/2019
Check #: 0
Check Amount: 206.11
Alt ID#: [redacted]

Insured: [redacted] **Insured Id:** [redacted] **Patient Account #:** [redacted]
Claim #: [redacted] **Provider/Practitioner:** [redacted]

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	23.40
Refund Amount	0.00
Refund Check #	

Previous Balance	0.00
Remittance Total	206.11
Interest Total	0.00
Check Amount	206.11

Comment Codes	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"

Molina Healthcare of Illinois
200 Oceangate, 6th Floor
Long Beach, CA 90802

Temporary Return Service Requested

DATE:
NPI:
TAX ID:
Check or EFT Trace #

EXPLANATION OF PAYMENT

SUMMARY OF PAYMENT

Billed Amount:	Refunds:
Contract/Allowed Amt:	Interest:
Disallow Amount::	Coinsurance:
Gross Plan Payable:	Deductible:
COB Amt:	FFS Withhold:
Co-Pay:	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.

IMAGE CO

US BANK
HAVRE, MT
93-455/929

Molina Healthcare of Illinois
200 Oceangate, 6th Floor
Long Beach, CA 90802

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

Explanation of Payment for:

NPI:
TAX ID:

Molina Healthcare of IL

Paid Date: **Check or EFT Trace #**

Claim Line	Date ServiceFrom / ServiceThru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd

Patient Name: **Member ID#:** **Payer Claim Ctrl#:** **Patient Control #:**
Rendering Provider Name: **NPI#:** **Program:**

TOTAL AMOUNT:

Claim Line	Date ServiceFrom / ServiceThru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd

Patient Name: **Member ID#:** **Payer Claim Ctrl#:** **Patient Control #:**
Rendering Provider Name: **NPI#:** **Program:**

TOTAL AMOUNT:

Claim Line	Date ServiceFrom / ServiceThru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd

Patient Name: **Member ID#:** **Payer Claim Ctrl#:** **Patient Control #:**
Rendering Provider Name: **NPI#:** **Program:**

TOTAL AMOUNT:

***Msg:**

000452-000005-000014-004998 2205313 1060CK01F

EXPLANATION OF PAYMENT

Explanation of Payment for:

NPI:
TAX ID:

Molina Healthcare of IL

Paid Date: **Check or EFT Trace #**

000452-000006-000014-004999 2205313 1060CK01F

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	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)
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.

IMAGE COPY

RMK CODE	DESCRIPTION
N19	Procedure code incidental to primary procedure.

Appendix E: Educational EOPs by MCO

Aetna Better Health of Illinois	Pages E-2 to E-5
Blue Cross Community Health Plans	Pages E-6 to E-7
County Care Health Plan	Page E-8
MeridianHealth	Page E-9
Molina HealthCare	Pages E-10 to E-11

P779902800F

aetna™

Aetna Better Health of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

202101040124
COPY

Return Service Requested

ALL FOR AADC 630
10271 0.7130 AB 0.416
XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX 167
XXXXXXXXXXXXXXXXXXXXXX

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

1 OF 3 F

ENV 10271

	Remit Date:	01/05/2021
• G	→ **Beginning Balance:**	0.00
• H	→ **Processed Amount:**	1,653.20
• I	→ **Discount/Interest:**	0.00
• J	→ **Net Amount:**	1,653.20
• K	→ **Refund Amount:**	0.00
• L	→ **Amount Recouped:**	0.00
• M	→ **Amount Paid:**	1,653.20
• N	→ **Ending Balance:**	0.00
• O	→ **EFT Reference #:**	XXXXXXXXX
• P	→ **EFT Amount:**	1,653.20
• Q	→ **Bank Account:**	XXXXXXXXXX XX

XXXXXXXXXXXXXXXXXXXXXX
TIN: XXXXXXXXX
NPI: XXXXXXXXX

Benefit Plan: Aetna Better Health of Illinois

Patient: XXXXXXXXX
• A→ **Member ID:** XXXXXXXX
Date of Birth: XX/XX/XXXX
Final DRG:
Place of Service: 131

• C → **Patient Acct #:** XXXXXXXXXXXXX
Authorization ID:
Provider: XXXXXXXXXXXXXXXXX
Severity of Illness:

Claim Status: PAID
Claim#: XXXXXXXXXXXXX
Refund Amount: 0.00
Received Date: 20201228

• B ↓ • D ↓ • F ↓

Line	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Unit	Billed Amount	Disallowed	Allowable Amount	Patient Responsibility Co-Pay	Patient Responsibility Ded.	Patient Responsibility 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
					Claim Totals		410.00	0.00	14.72	0.00	0.00	0.00	0.00	14.72	0.00	14.72

• E ↓

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 claims

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 run.

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.

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3200 Highland Avenue, MC F648
Downers Grove, IL 60515

XXXXXXXXXXXXXXXXXXXXXX

TIN: XXXXXXXXX
NPI: XXXXXXXXX

COPY

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

Remit Date: 01/05/2021
EFT Reference #: XXXXXXXXXXX
Benefit Plan: Aetna Better Health of Illinois

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 Aetna 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:

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).

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

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.

7) 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

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

P7799028001

202101040124

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Aetna Better Health of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

COPY

Return Service Requested

ALL FOR AADC 630
10271 0.7130 AB 0.416

XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX

167

3 OF 3 F

ENV 10271

Claim Number: XXXXXXXXX
Check Number: XXXXXXXXX
Check Date: 01/05/2021
Check Amount: $1,653.20

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Aetna Better Health of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

91-170
1221

EFT REF #: XXXXXXXX
REMIT DATE: 2021/01/05

AMOUNT
*****$1,653.20

Void After 180 Days

PAY One Thousand Six Hundred Fifty Three & 20/100 Dollars

TO THE ORDER OF XXXXXXXXXXXXXXXXXXXXXXXX
PAYMENT MADE ELECTRONICALLY

Bank of America

Electronic Funds Transfer XXXXXXXX

NON-NEGOTIABLE
NON-NEGOTIABLE
VOID

PEFTCHECK P7799000000

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Aetna Better Health of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

Return Service Requested

4574 0.0124

XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX

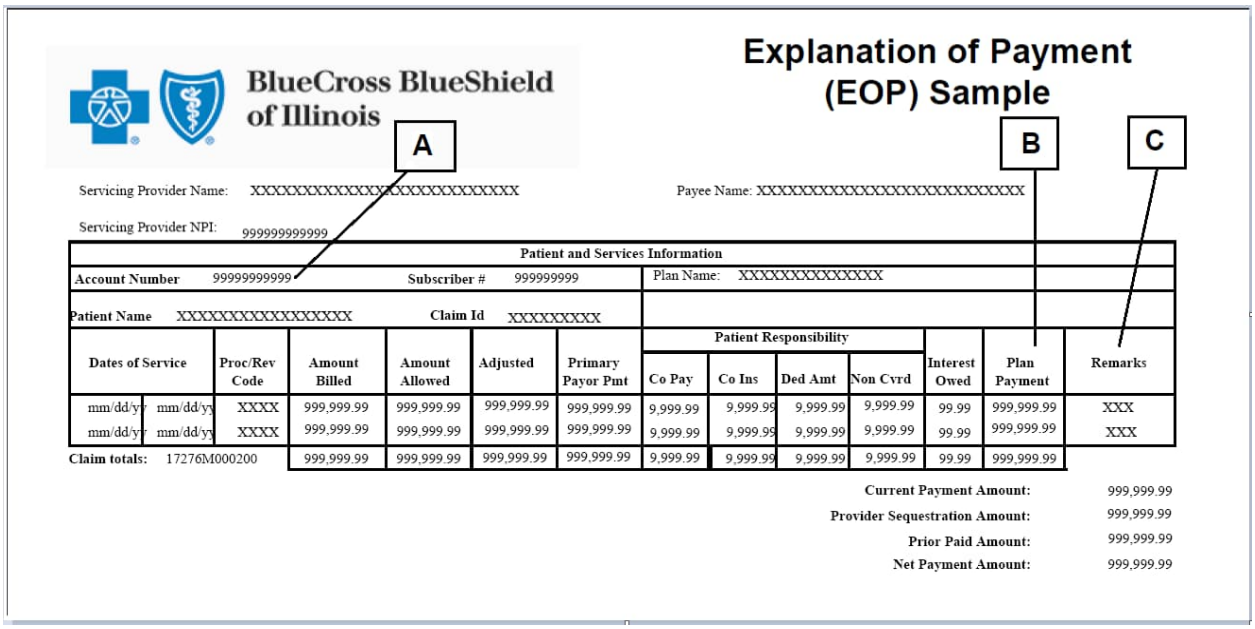
202101043000

Payee Name:	XXXXXXXXXXXXXXXXXXX
Payee Bank:	XXXXXXXXXXXXX
ACH Amount:	XXXXXXX
ACH Bank ID:	XXXXXXX

ENV 4574 1 OF 1

ACH Transaction

VOID



BlueCross BlueShield of Illinois

Explanation of Payment (EOP) Sample

A

B

C

Servicing Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Payee Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Servicing Provider NPI: 9999999999

Patient and Services Information

Account Number 99999999999 Subscriber # 999999999 Plan Name: XXXXXXXXXXXXXX

Patient Name XXXXXXXXXXXXXXXXX Claim Id XXXXXXXXX

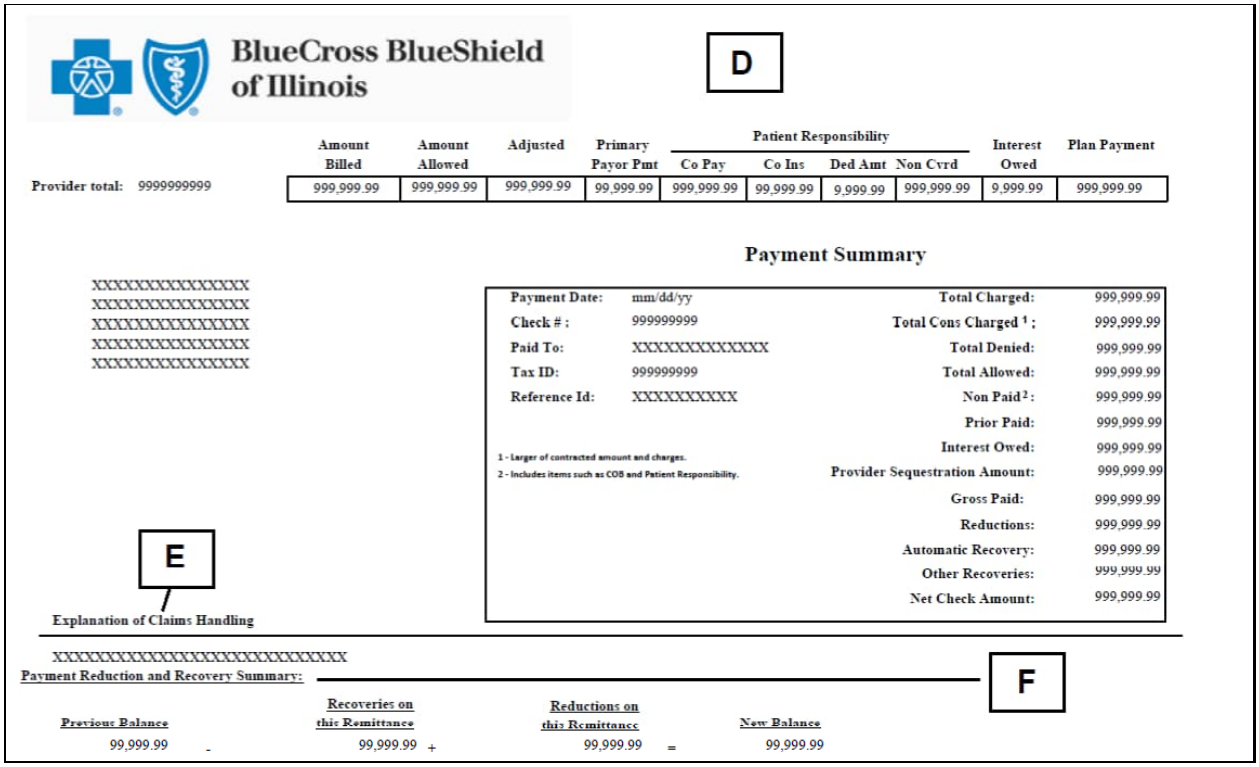
Dates of Service		Proc/Rev Code	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Interest Owed	Plan Payment	Remarks
							Co Pay	Co Ins	Ded Amt	Non Cvrd			
mm/dd/yy	mm/dd/yy	XXXX	999,999.99	999,999.99	999,999.99	999,999.99	9,999.99	9,999.99	9,999.99	9,999.99	99.99	999,999.99	XXX
mm/dd/yy	mm/dd/yy	XXXX	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	XXX
Claim totals:	17276M000200		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



BlueCross BlueShield of Illinois

D

	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Interest Owed	Plan Payment
					Co Pay	Co Ins	Ded Amt	Non Cvrd		
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

XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Payment Summary

Payment Date:	mm/dd/yy	Total Charged:	999,999.99
Check # :	999999999	Total Cons Charged [1] :	999,999.99
Paid To:	XXXXXXXXXXXXX	Total Denied:	999,999.99
Tax ID:	999999999	Total Allowed:	999,999.99
Reference Id:	XXXXXXXXXX	Non Paid [2] :	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
		Other Recoveries:	999,999.99
		Net Check Amount:	999,999.99

E

Explanation of Claims Handling

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Payment Reduction and Recovery Summary:

F

Previous Balance		Recoveries on this Remittance		Reductions on this Remittance		New Balance
99,999.99	-	99,999.99	+	99,999.99	=	99,999.99



Negative Balance Details: G

Creation Date	Reduction Type	Original Claim Information	Original Reduction	Prior Recovery	Current Recovery	Current Balance
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXX Dates of Service: mm/dd/yy- mm/dd/yy Patient Account #: XXXXXXXXXXXX Original Claim Control #: XXXXXXXX Original Check #: XXXXX Original Check Date: mm/dd/yy LOB: XXXXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
mm/dd/yy	Medical Overpayment	Patient Name: XXXXXXXXXXXX Dates of Service: mm/dd/yy- mm/dd/yy Patient Account #: XXXXXXXXXXXXX Original Claim Control #: XXXXXXXX Original Check #: 99999 Original Check Date: mm/dd/yy LOB: XXXXXXXXXXXXXXX	9999.99	9999.99	9999.99	9999.99
mm/dd/yy	Manual Reduction		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.

EOP Field Definition & Interpretation

Procedure – Code for service rendered.

No. of Units – No. of Units refers to the quantity of a specific service rendered.

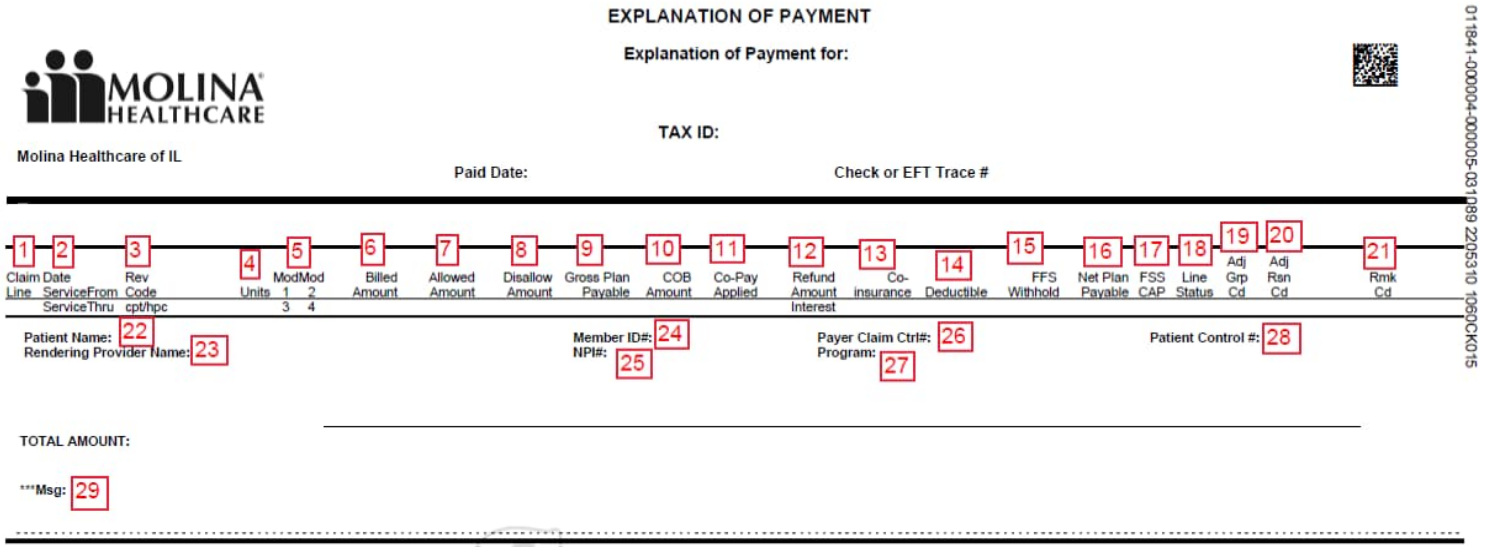
COB – Coordination of Benefits indicating a third-party payment

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.

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

Explanation of Payment for:

MOLINA HEALTHCARE

TAX ID:

Molina Healthcare of IL

Paid Date: Check or EFT Trace #

1 Claim Line	2 Date ServiceFrom ServiceThru	3 Rev Code cpt/hpc	4 Units	5 Mod 1 Mod 2 Mod 3 Mod 4	6 Billed Amount	7 Allowed Amount	8 Disallow Amount	9 Gross Plan Payable	10 COB Amount	11 Co-Pay Applied	12 Refund Amount Interest	13 Co-insurance	14 Deductible	15 FFS Withhold	16 Net Plan Payable	17 FSS CAP	18 Line Status	19 Adj Grp Cd	20 Adj Rsn Cd	21 Rmk Cd

Patient Name: 22
Rendering Provider Name: 23

Member ID#: 24
NPI#: 25

Payer Claim Ctrl#: 26
Program: 27

Patient Control #: 28

TOTAL AMOUNT:

***Msg: 29

011841-000004-000005-031089 2205310 1060CK015

0 1060CK015

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.

IMAGE COPY

1. **Claim Line** – The claim line number
2. **Dates of Service** – The date range for services rendered
3. **Rev/CPT/HPC Code** – Codes billed per that line
4. **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 EOP (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 and Forms

IAMHP
ILLINOIS ASSOCIATION OF MEDICAID HEALTH PLANS

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. **NOTE:** If Part IV is submitted, Parts II and III do NOT need to be completed. (Part I is always required).

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

PART I - (MUST BE COMPLETED)

Recipient Name _____

Recipient Identification No. _____ Provider No. _____

Physician Name _____ NPI No. _____

PART II - ACKNOWLEDGEMENT

It has been explained to _____
and the patient's representative, if any, orally and in writing that the hysterectomy to be performed on the patient will render the patient permanently incapable of reproducing.

_____ _____
Recipient or Representative Signature Date:

_____ _____
(If required, Interpreter Signature) Date:

PART III - PHYSICIAN STATEMENT

In my professional judgment, the hysterectomy is not being performed solely to accomplish sterilization; it is being performed for other medically necessary reasons.

_____ _____
Physician Signature Date:

PART IV - EXCEPTION REQUEST

- Exception 1 - I certify that the above named individual was already sterile at the time of the hysterectomy. The cause of the sterility was _____
- Exception 2 - I certify that the hysterectomy performed on the above named individual was performed under a life threatening emergency situation,
  i.e. _____
  in which I determined prior acknowledgment of receipt of hysterectomy information was not possible. I have attached a copy of the hospital operative record or other written explanation as to the nature of the emergency.
- Exception 3 - The above named individual had a hysterectomy performed during a period of retroactive Medicaid eligibility. Date of Surgery _____

I certify that the above named individual was informed prior to the operation that the hysterectomy would render the patient permanently incapable of reproducing; or that Exception 1 ☐ or that Exception 2 ☐ as certified above, made such explanation unnecessary or impossible.

_____ _____
Physician Signature Date:

Completion mandatory, 305 ILCS 5/1-1 et seq., penalty non-payment.
Form approved by 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.

IHFS Illinois Department of Healthcare and Family Services

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 ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____.

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

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 time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____ hereby consent of my own free will to be sterilized by

_____ (Doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed

I have received a copy of this form.

_____ (Signature) Date _____ (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (Interpreter) _____ (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary, I explained that sterilization is different because it is permanent.

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 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 mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ (Signature of person obtaining consent) _____ (Date)

_____ (Facility)

_____ (Address)

■ PHYSICIAN'S STATEMENT ■

Completion Mandatory, 305 ILCS 5/1-1 et seq., penalty non-payment.

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization operation),

I explained to him/her the nature of the sterilization operation _____ (Specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

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 services 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 mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure. (Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____

_____ (Physician) _____ (Date)

HFS 2189 (R-7-06) IL478-1071

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 implemented requirements for ordering, referring and prescribing (ORP) National Provider Identifier (NPI)s to be included on medical and pharmacy claims.

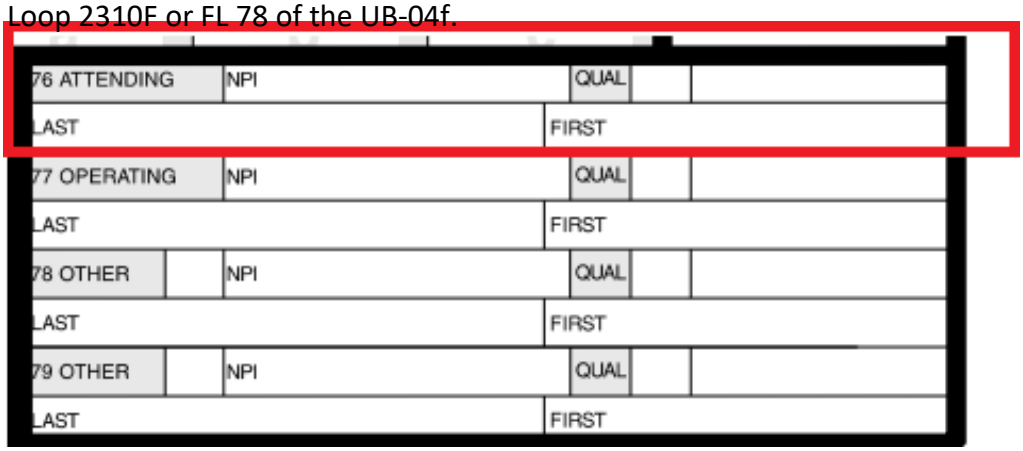
A. Hospice, Ambulatory Surgical Treatment Centers and Hospital Provider Types Billing on the UB04/837I ORP Requirements

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 on the Illinois IMPACT and be actively enrolled and be an individual (not an entity) 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-04f.



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

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 and Box 76 are present and in proper order for an NPI, if not proper or missing generate error = 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. 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 Individual

MCOs will generate edits in the same manner 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

   The NPI is present and passes the NPI check in number 1 but the NPI is not for an individual. 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. Provider Types Billing on the CMS1500/837P ORP Requirements

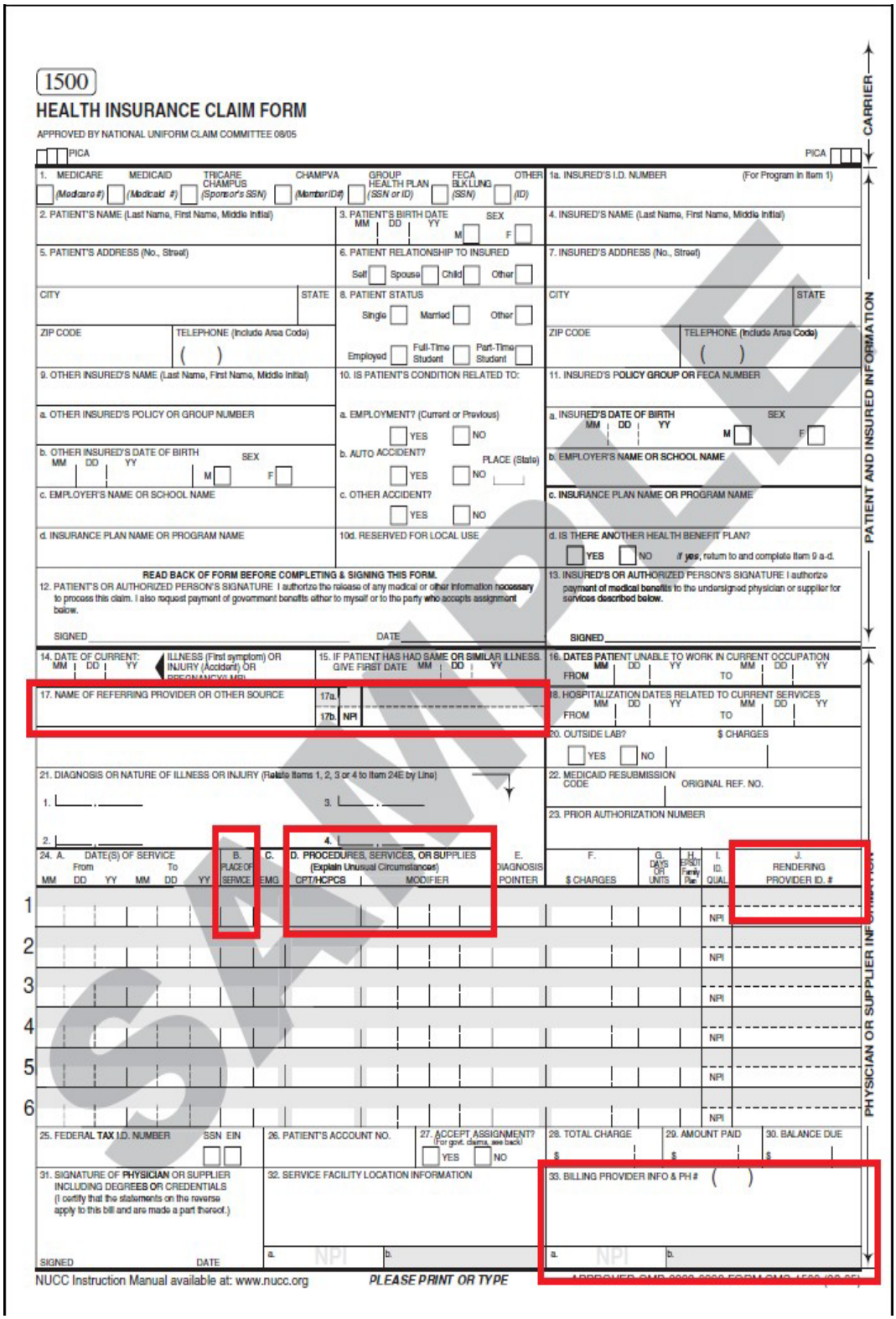
HFS and MCOs will use Box 17A for NPI validation from the CMS 1500 paper format. Additionally, HFS and the MCOs will use 2310A (Referring – Qualifier DN) and 2420E (Ordering-Qualifier DK) loops for NPI validation via the 837P for certain scenarios (defined later in this section).

Additionally, there will be dependencies on the data billed in the following portions billed on the paper form and 837P:

- Box 24D- Procedure, Services or Supplies on the paper form (2400 Loop SV101)
- Box 24B- Place of Service on the paper form (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 we need to consider for this HFS initiative.

http://www.nucc.org/images/stories/PDF/1500_claim_form_map_to_837P_v3-3_2012_02.pdf



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL 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. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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.

Defining the ORP Relationship is required as follows on the CMS 1500/837P:

Table 1 below reflects HFS guidance from the 11/9/18 HFS provider notice.

Note: The 11/9/18 notice omitted the fact that this applies to **any** provider billing E&M consultations when the patient resides in a Skilled Nursing Facility (31), Nursing Facility (32) or Custodial Care Facility (33), not just Optometrists or Podiatrists. 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 evaluates 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 • FQHC, ERC, RHC	• Advanced Practice Nurse • 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 consultation and procedure code is between 99201-99499)	• Podiatrist
The ORP is required on all claims for the following providers:	
• Physical Therapist • Occupational Therapist • Speech Pathologist • Audiologist • LEA (when billing OT, PT, Speech, Audiology) • Home Health Agency • Community Health Agency • Home Nursing Agency	• Hospital Billing fee-for-service • Durable Medical Equipment and Supplies • Independent Diagnostic Testing Facilities • Independent Laboratory • Imaging: Portable X-ray • Imaging Centers • Optical Supply Companies • Certified Health Department

Following the direction above, the ORP provider in Box 17 will be validated per CMS1500/837P ORP Requirements based on the following grid using the 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	99241-99245: these are defined as office/outpatient codes. Example: 11, 22, 23 etc.
040 Federally Qualified Health Centers (FQHC)		
048 Rural Health Clinics		
016 Nurse Practitioners		
013 Podiatrists		
012 Optometrists	99251-99255	99251-99255: these are defined as Inpatient codes. Example: 21
089 Physician Assistant		

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*
013 Podiatrists	ALL	31, 32 or 33
012 Optometrists	99201 - 99499	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
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 Hospital 31 Psych 32 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. 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.	ALL	ALL
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

C. Pharmacy ORP Requirements

MCO Pharmacy claims will no longer allow prescriptions from non-registered prescribers.

Effective January 1, 2020, Prescriptions will be denied if Provider is not registered with IMPACT.

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.

Appendix H: MCO Recoupment EOPs

Aetna Better Health of Illinois	Pages H-2 to H-3
Blue Cross Community Health Plans	Pages H-4 to H-6
County Care Health Plan	Page H-7
MeridianHealth	Pages H-8 to H-9
Molina HealthCare	Pages H-10 to H-11

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:

CR Log #	CR Log Description



BlueCross BlueShield of Illinois

[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)℠ 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

BlueCross BlueShield of Illinois

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

BlueCross BlueShield of Illinois

[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]

Group and ID Number: [GRGR_ID] and [SBSB_ID]

Claim Number: [ORIG_CLCL_ID]

Amount Requested: $[RECOUP_AMOUNT_DUE]

Amount Remitted: $_____

If the amount remitted is different from the amount requested, please explain:

_____

_____

_____

_____

_____

Signature: _____Telephone Number: _____

PAYMENT COUPON - PLEASE RETURN THIS 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**	**Billed**	**Paid**	**Overpayment**
[Cl#]	[Pt Name]	[Medicaid #]	[Paid Date]	[Admit-Disch]	$[Total Charges]	$[Paid]	$[Refund Amount]

Mail refund check or dispute letter to:
County Care Health Plan
Attn: Funding and Recovery Dept.
P.O. Box 211592
Eagan, MN 55121-2892

<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 > Providers > Provider Resources > Documents and Forms > Request for Claim Dispute Form.**

Sincerely,

Meridian

Provider Name: <ProviderName>

Provider ID (and TIN) : <ProviderID>

Member Name: <MemberName>

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>

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:	18348161141	**Billed Amount:**	$306.60
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:	$27.93	**FFS withhold:**	$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,

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:	$34.26	**FFS withhold:**	$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

Appendix I: Administrative Days

ADMINISTRATIVE DAYS REIMBURSEMENT

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 and MMAI 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
    - 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;
    - 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:

- Claim 1: 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. These claims will not include the day of discharge in the Value Code 80 calculation.
- Claim 2: 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. The Admission Date on the claim should be the date of admission into the AD stay.

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. Interim claims (BT 112 or 113) should include all days in the Value Code 80 calculation. The initial claim (BT 111) and interim final (BT 114) should not include the day of discharge in the Value Code 80 calculation.

Billing Scenarios

Scenario One:

IP psych admission 20 days (Jan 1-21) Admit date 1/1/23	Claim 1: BT 111 with DSC of 95 Value Code 80 = 20*
AD Stay for 6 days (Jan 22-28) Admit date 1/22/23	Claim 2: BT 111 with DSC XX(as appropriate) Value Code 80 = 6*

* *Date of discharge is **NOT** included in Value Code 80 calculation*

Scenario Two:

IP psych admission 14 days (Jan 10-24)	Claim 1: BT 111 with DSC of 95
Admit date 1/10/23	Value Code = 14*
AD stay for 45 days (Jan 25-Mar 3)	
Admit date 1/25/23	Claim 2: BT 112 with DSC of 30 (Jan 25-31)**
Admit date 1/25/23	Claim 3: BT 113 with DSC of 30 (Feb 1-28)**
Admit date 1/25/23	Claim 4: BT 114 with DSC of XX (Mar 1-3)*

Scenario Three±:

IP psych admission 19 days (Jan 1-20)	Claim 1: BT 111 with DSC of 95
Admit date 1/1/23	Value Code 80 = 19*
AD stay for 30 days (Jan 21-Feb 20)	
Admit date 1/21/23	Claim 2: BT 112 with DSC of 30 (Jan 21-31)**
Admit date 1/21/23	Claim 3: BT 114 with DS of XX (Feb 1-20)*

Scenario Four:

IP Medical Admission 44 days (Jan 1-Feb 14)	Claim 1: BT 111 with DSC of 95 (Jan 1-Feb 14)*
Admit date 1/1/23 Value Code 80 = 44	
AD stay for 60 days (Feb 15 – Apr 16)	
Admit date 2/15/23	Claim 2: BT 112 with DSC of 30 (Feb 15-28)**
Admit date 2/15/23	Claim 3: BT 113 with DS of 30 (Mar 1-31)**
Admit date 2/15/23	Claim 4: 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.

** *Date of discharge **IS** included in Value Code 80 calculation*

± *See UB-04 claim examples at the end of this Appendix*

* *Date of discharge is **NOT** included in Value Code 80 calculation*

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 Ill. 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.

Charges for MCO Patients Whose Coverage Begins or Ends during a Hospital Long Term Care Day

- MCO Coverage Beginning During Hospital Long Term Care Stay
    - If an individual is receiving hospital long term care services (ADs), as defined at 89 Ill. 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 Ill. 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
ABH (CVS/Aetna)	ABH – IL Readmission Policy	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
Meridian (Centene)	MeridianHealth Readmission Policy (06/01/21)	Policy is active
Molina	Molina IL Readmissions Policy (06/10/21)	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/illinois/assets/pdf/OnlineProviderDisputeInstructions_IL.pdf

Provider Manual –
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/Aetna%20Better%20Health%20of%20Illinois%20Provider%20Manual.pdfht

MCO Assigned Tracking Number Examples:

Tracking ID before 2-27-2022:
#####E########A# Tracking ID effective 2-27-2022: TMMDDYY#X##X#

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

claim number #####E########A# plus characters ending in A1, A2, A3, etc.).

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

Provider Claims Inquiry or Dispute Form:
https://www.bcbsil.com/pdf/network/medicaid_claims_inquiry_dispute_request_form.pdf

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.

- First two digits are the year BCBSIL received the dispute: 19
- Next 3 digits are the date or the calendar day BCBSIL received the dispute, for example, 345 represents December 11 (the 345th day of the year)
- The remaining digits uniquely identify the dispute in the BCBSIL system

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 if you submitted via mail or fax.

- 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://jira.evolenthealth.com/servicedesk/customer/portal/25/user/login?nokerberos&destination=portal%2F25%2Fcreate%2F90

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.external.pioneer.humana.com/Marketing/docushare-app?file=3942328

MCO Assigned Tracking Number Example:

When submitting a complaint/dispute to:

- Humana:
  - 12-13 character alphanumerical code
- Provider Portal (Availity):
  - 32-36 character alphanumerical code, depending upon inclusion of the dashes
- Beacon (Humana Behavioral Health):
  - 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:

HealthChoice Illinois -

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.htmlht

Claims with a date of service July 1, 2021 or earlier
Provider Notice –

https://www.ilmeridian.com/newsroom/mcs-sunsetting-and-reminders-on-timely-claim-filing-limits--comp.htmlht

YouthCare –

Provider Manual:
https://www.ilyouthcare.com/content/dam/centene/meridian/il/pdf/IL%20YouthCare%20Provider%20Manual%20CVS_FINAL_2_2022.pdf

MMAI –

Login

MCO Assigned Tracking Number Examples:

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 YouthCare, MMAI and HCI 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.

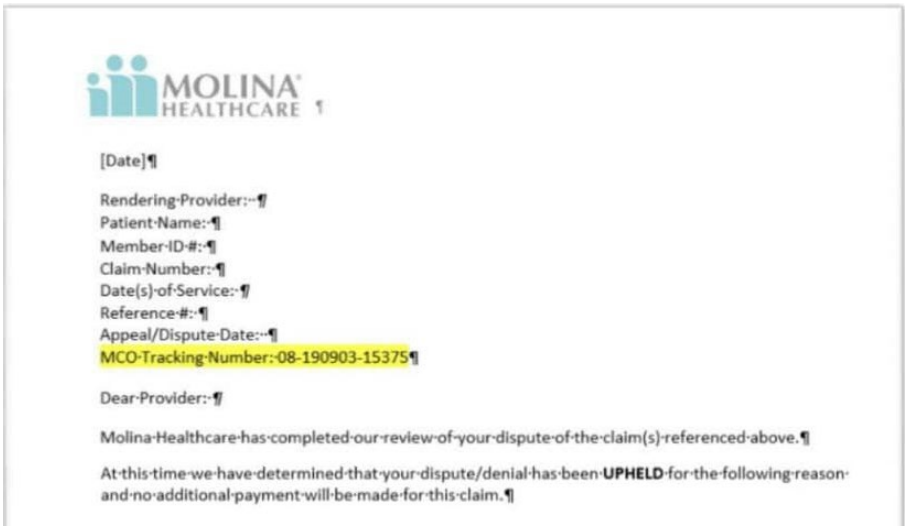
Molina:

MCO Internal Dispute Process Instructions:

Complaint Tracking Memo –

HFS-Complaint-Tracking-Provider-Memo_clean-FNL.pdf

MCO Assigned Tracking Number Examples:



MOLINA HEALTHCARE

[Date]

Rendering Provider:
Patient Name:
Member ID #:
Claim Number:
Date(s) of Service:
Reference #:
Appeal/Dispute Date:
MCO Tracking Number: 08-190903-15375

Dear Provider:

Molina Healthcare has completed our review of your dispute of the claim(s) referenced above.

At this time we have determined that your dispute/denial has been **UPHELD** for the following reason and no additional payment will be made for this claim.

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.

Appendix L: Coordination of Benefits (COB)/Third Party Liability (TPL) Policies

Overview

The primary intention of coordination of benefits is to make sure that individuals who receive coverage from two or more plans receive their complete benefit entitlement and to prevent benefits from being duplicated when an individual has more than one policy in place. In addition, for state Medicaid programs, by law, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as "third party liability" or TPL. Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute). Third party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State plan.

In general, if a State has determined that a potentially liable third party exists, it must attempt to ensure that the provider bills the third party first before sending the claim to Medicaid. This is known as "cost avoidance." Whenever a State has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party. This is known as "pay and chase." States are required to cost-avoid claims, with a few specific exceptions which are identified in regulation.

If a provider accepts the participant as covered under HFS' medical programs, the provider may not charge the participant for co-payments, participation fees, deductibles, or any other form of participant cost-sharing, except as specifically allowed under the participant's coverage with HFS. In no other instance may any form of participant cost sharing be charged to eligible participants for any service covered by HFS.

Providers cannot bill HFS for the co-payment. When private insurance does not pay on a claim because the participant's deductible has not been met, the provider may bill HFS with TPL status code 10 – deductible not met. HFS' reimbursement will be based on its fee schedule.

If a provider accepts a participant as 'private insurance only', the provider can collect the private insurance co-payment from the participant.

Timely filing of secondary TPL claims is based on the primary payer's claim adjudication date paid/processed date to determine if the submission was timely, not the claim date of service. Please refer to the timely filing section of this manual for more information per each MCO of those specific limits.

As noted on the HFS Non-Institutional Providers web page, under Participants Liability and Co-Payments, below are some key concepts for providers related to participant liability for payments related to MCOs:

- Under what circumstances is a participant liable for payment for non-covered services?

  Response: All providers may charge a customer they have accepted as covered by Medicaid for non-covered services. The provider must inform the customer before services are rendered that

they will be responsible for payment. The customer then has the choice to receive the services or not.

- Can a provider charge a co-payment for Medicaid family planning services?

Response: Federal regulations stipulate those customers receiving family planning medical services and contraceptive methods cannot be charged a co-pay. This applies to all customers covered under the Department of Healthcare and Family Services (HFS)' medical programs.

- An enrolled anesthesiologist provides anesthesia for a surgery that turns out to be a non-covered service. The anesthesiologist has no opportunity to verify eligibility, nor does the anesthesiologist have the opportunity to inform a customer before rendering services if the service will not be covered by Medicaid. Can the anesthesia provider bill the customer?

Response: Yes, if anesthesia was provided for a non-covered service (e.g., cosmetic surgery, fertility treatment, etc.) the provider may bill the customer. Billing the customer, or balance billing the customer, is only prohibited if reimbursement for the service would have been available if the provider had timely and properly billed the Department.

- Customer is in an MCO. Customer goes to a provider not enrolled with the MCO and therefore the services are not covered by the MCO. Is the customer liable?

Response: Customer is not liable. Provider should have verified eligibility on MEDI prior to rendering services. Provider's only option is to contact the MCO to see if anything can be arranged between the MCO and the provider.

- Can an enrolled provider charge an HFS customer for missing appointments?

Response: No, according to federal statutes and regulations Medicaid customers must not be charged for missed or canceled appointments. If no service was delivered, no reimbursement is available. Also, missed appointments are not a distinct, reimbursable Medicaid service, and are considered part of a providers' overall cost of doing business.

- Can a provider charge an HFS participant for copies of their medical records?

Response: Yes, if the provider has a written office policy to charge all patients for these services, that policy may be applied to HFS participants.

- Can a provider charge an HFS participant to transfer medical records to another provider?

Response: No, medical records are to be made available to other health care providers who are treating or serving the participant, without charge and in a timely manner, when authorized by the participant in writing.

A few important notes:

Health Choice MLTSS Membership:

- When a member is part of the MLTSS program with HFS, it means the member has picked their **Medicaid only** services to be handled with the specific MCO for the state of Illinois Medicaid program.
- These members are ALSO COVERED with a Medicare plan.

- For MLTSS participants, the Medicare plan is not handled through the enrolled MCO, otherwise the member would be in the MMAI product offering at the given MCO.
- Medicare covered services in MLTSS will be denied as not covered by the Medicaid-only service MCO.
- The MCO will NOT request a Medicare EOB for a Medicare service as MLTSS Medicare services are NOT paid by the MCO the member is enrolled with for Medicaid only services. The Medicare service is paid by another carrier and the provider needs to submit the Medicare service to the proper carrier for reimbursement of the Medicare services.

MMAI Membership:

- The MMAI plan is for members enrolled with the assigned MCO for their Medicare AND Medicaid coverage. MMAI MCOs are responsible for claims for both Medicare services and Medicaid services. There is no coordination of benefits on MMAI. The Medicare portion is calculated for dually eligible services and the Medicaid-only services are reviewed for processing by the MMAI participant's MCO.

HealthChoice Illinois:

- There is an MCO contract provision that does NOT allow any MCO to deny a claim for Third Party Liability. The contract states the following items cannot be denied for TPL effective 10/1/2023:
  - Preventative pediatrics
  - EPSDT services
  - HCBS waiver services (Supportive Living Facility/Supportive Living Program (SLF/SLP) stays (HFS Provider Type 28) claims are part of this category)

  There may be times where the member seeking these services has primary insurance in addition to Medicaid. In these instances, by contract the MCO must pay the claim as primary. The MCOs are not allowed to deny the claim. The MCO will pay the claim and recoup from the other insurer. This is a "pay and chase" situation.
- TPL Recoveries - If an MCO pays a claim to a provider and later finds there is TPL in place, the MCO is not allowed to recoup the funds from the provider. The MCO is required to work with the private insurer to recoup the funds.

HFS Provider-Specific Rules for TPL

Non-Institutional Providers

- Encounter Rate Clinics (ERC) defined as HFS Provider Type 040 (Federally Qualified Health Centers (FQHC), 048 (Rural Health Centers (RHC) and 043 (ERC)) have provider-specific rates based on their cost reports. For these provider types, "lesser of" logic (lesser of the provider charge or state max, minus any TPL payments or applicable HFS copays) does not apply, as the provider-specific rate is used for the state max amount (regardless of provider charge), and then any TPL payments or applicable HFS copays are subtracted from that rate. Note: Another example of this type of provider is Local Education Agencies (LEA), HFS Provider Type 047. LEAs are not paid by MCOs, they are only reimbursed in FFS.

- For other providers (i.e., those without a provider-specific rate driven by cost report) 'lesser of' logic does apply and will be processed according to non-institutional reimbursement rules at HFS.

Global Maternity Care Billing – **EFFECTIVE 10/1/23**

- The global obstetric (OB) care package is a complete one-time billing structure that includes professional services for the provision of prenatal care visits and the delivery. The global OB care period begins on the date of the initial prenatal visit. *The global OB billing methodology outlined below applies only to members with primary TPL*. If there is no TPL involved and Medicaid is the primary payor, Individual Maternity Service Billing Rules apply (found under the Pregnancy/Maternity section of PART C.IV.I: Family Planning, Pregnancy/Maternity and Reproductive Health Care). This guidance also applies to FQHCs, RHCs, and ERCs.
- For maternity care already in progress on 10/1/2023 date:
    - When Medicaid is the primary payor - Providers should continue billing for antepartum care and the delivery using individual maternity service codes, following the rules and new modifiers noted in the Individual Maternity Service Billing Rules section. See link above.
    - When the member has TPL – Providers should void out claims sent to the MCO as individual services (if this exists) when the delivery occurs on/after 10/1/2023 and rebill the TPL using global OB care coding.
- When billing global OB care codes, the date of service is the delivery date. Reimbursement for global OB care is inclusive of the customer's antepartum care and the delivery when rendered by the same provider or provider group.
- Initial claim needs to be billed with 0500F **with no modifier** on a separate service line of the same claim containing the appropriate global OB care code. Reimbursement for the 0500F initial claim will be $0 and is required on the claim for HEDIS reporting.
- The U4 modifier is not allowed on global billings for 0500F.
- Global Codes for TPL Claims (when Medicaid is NOT primary)
    - 59400 – Routine obstetric care, including antepartum care and vaginal delivery (with or without episiotomy and/or forceps)
    - 59510 – Routine obstetric care, including antepartum care and cesarean delivery
    - 59610 – Routine obstetric care, including antepartum care and vaginal delivery (with or without episiotomy and/or forceps) after previous cesarean delivery
    - 59618 – Routine obstetric care, including antepartum care and cesarean delivery following attempted vaginal delivery after previous cesarean delivery
- Global OB Codes used with Multiple Births: To accurately capture the work performed, billing and coding need to be specific to every gestation.

  1) Vaginal delivery:

  a. Baby #1: Submit using the global OB CPT code appropriate for vaginal delivery, as well as the initial prenatal care code 0500F with no modifier and $0 charge on the same claim.

b. Baby #2 and beyond: Submit using the unlisted procedure code with the applicable description “twin, triplet, etc.” in the NTE segment of the electronic 837P. A separate service line using the unlisted procedure code and applicable description should be submitted for each multiple delivery.

2) Cesarean delivery:

a. Baby #1 and beyond: Submit (*only once) using the global OB CPT code appropriate for cesarean delivery, as well as the initial prenatal care code 0500F with no modifier and $0 charge on the same claim.

3) Vaginal delivery, followed by Cesarean delivery:

If one baby is delivered vaginally and the other(s) by cesarean section, bill the correct code for each delivery type with separate charges in the following manner, and attach both delivery reports to the claim.

a. Baby #1: Submit using the individual maternity procedure code appropriate for vaginal delivery only, as well as the initial prenatal care code 0500F with no modifier and $0 charge on the same claim.

b. Baby #2 and beyond: Submit (*only once) using the global OB CPT Code appropriate for cesarean delivery. Note: Cesarean delivery codes should be reported only once regardless of the number of babies delivered.

- Postpartum Care Billing- (0503F will be discontinued by HFS as of 9/30/2023)
  - 59430 - Postpartum care code
- As a reminder, postpartum bonus payments were introduced effective January 1, 2023. In accordance with the February 21, 2023 provider notice, bonus payments will be reimbursed and are dependent upon reporting of the actual delivery date on the postpartum visit claim.
  - Providers must include the actual delivery date in Loop 2300, Segment DTP*454 ‘Initial Treatment Date’, of the 837P. The provider is eligible for bonus payments if a postpartum visit occurs within the first 26 days following the delivery date, and/or if a postpartum visit occurs within 27-89 days following the delivery date, as reported on the claim. Each of these time periods will have a limit of one payable bonus payment. Payment of a bonus payment for the 27-89 days post-delivery time period is not dependent upon there having been a payment during the first 26-days post-delivery time period. For instances when more than one claim is received during the same time period, the bonus payment will be reimbursed on the first claim received.

MCO-Specific Guidance when Provider Discovers TPL Coverage is Termed

Aetna Better Health® of Illinois	Provider can contact the Provider Services Call Center, advise their PR representative, or notify the plan in writing through the dispute/reconsideration process. An EOB is not required. Once the Plan has validated the coverage termination, all impacted claims will be reprocessed.
Blue Cross Community Health Plan (BCCHP)	Providers do not need to submit an EOB when they are requesting a TPL validation or when submitting a claim dispute for TPL coverage termination. When providers learn that a BCBSIL member no longer has TPL coverage, there are two options to report: 1. Alerting customer service by calling 1-877-860-2837. Providers can request that a TPL validation is performed if they believe that the BCBSIL member no longer has other insurance. The following will be asked of the provider: a. Confirm demographic information of member b. Confirm the other health insurance (OHI) Name, Policy #, Group #, and Policy holder c. Date of OHI coverage termination (if known) 2. Submitting a claim dispute via phone or fax. The provider should indicate that they are contesting the claim denial due to BCBSIL member TPL coverage termination. a. Claim dispute filing instructions can be found here: https://www.bcbsil.com/provider/education/education-reference/news/2021-news-and-updates/07-21-21-dispute-process-government-programs Once the plan validates TPL coverage determination, all affected claims are reprocessed.
County Care Health Plan	Inquiries should be directed to the provider dispute process via the provider portal ticket process. An EOB is not needed for the claim. The Plan will verify additional insurance information and reprocess the disputed claim within that ticket. The ticket will then be transferred to the payment integrity team, which will assess previously impacted claims during the time frame and make any necessary adjustments to any previously denied claims.
Meridian	If a member's primary insurance has termed, the provider may send in a dispute notifying of the termination of coverage or call into the customer service line to notify of the termination of coverage and Meridian will verify coverage at that time. Meridian does not require the Certificate of Coverage or a copy of the EOP from a primary payor in order to term a primary insurance on file. Meridian will seek to reprocess all claims associated with the coverage termination but suggests providers include all relevant claims in the dispute.
Molina Healthcare	Providers have the option to submit a denial EOB with their claim, but it is not required. Outside that, providers should follow the standard dispute process. If they opt to file a dispute, the Dispute Form will need to state that there is no primary coverage on the DOS, and once received, the appeals team will send the claim/member to the enrollment team to verify and update eligibility/TPL information and adjust the disputed claim if appropriate.

TPL Examples

Example 1

Provider is an FQHC with an encounter rate for Medicaid of $88.15

The provider will bill Medicaid after primary payor as follows:

Date of Service	Procedure Code	Place of Service	Line Charge
7/5/2019	T1015	50	$155.00
7/5/2019	99202	50	$0.00
Total Charge			$155.00
Total Paid if Medicaid was the Primary Payor			**$88.15**
Total Allowed by Primary Carrier			*$88.20*
Total Paid by Primary Carrier			*$68.20*
Total allowed per Medicaid rate of $88.15 and patient balance liability is 20.00 per the member EOB.			$20.00 Copay - cannot be collected from the member since provider is billing Medicaid
The provider is entitled to their contracted rate with HFS of $88.15 $88.15 – $68.20 = $19.95 **Units Serv Code Billed Paid Allowed Adjustments** 1 HC:99202 $155.00 $68.20 $88.20 PR-2: $20.00 CO-45: $66.80			MCO should pay $19.95

Example 2

Provider is an FQHC with an encounter rate for Medicaid of $88.20.

The provider will bill Medicaid after primary payor as follows:

Date of Service	Procedure Code	Place of Service	Line Charge
7/5/2019	T1015	50	$155.00
7/5/2019	99202	50	$0.00
Total Charge			$155.00
Total Paid if Medicaid was the Primary Payor			**$88.20**
Total Allowed by Primary Carrier			*$88.20*
Total Paid by Primary Carrier			*$68.20*
Total allowed by per Medicaid rate of $88.15 and patient balance liability is 20.00 per the member EOB.			$20.00 Copay - cannot be collected from the member since provider is billing Medicaid
The provider is entitled to their contracted rate with HFS of $88.20. $88.20 – $68.20 = $20.00 **Units Serv Code Billed Paid Allowed Adjustments** 1 HC:99202 $155.00 $68.20 $88.20 PR-2: $20.00 CO-45: $66.80			MCO should pay $20.00

Example 3

Provider is an FQHC with an encounter rate for Medicaid of $119.16

The provider will bill Medicaid after primary payor as follows:

Date of Service	Procedure Code	Place of Service	Line Charge
7/5/2019	T1015	50	$155.00
7/5/2019	99202	50	$0.00
Total Charge			$155.00
Total Paid if Medicaid was the Primary Payor			**$119.16**
Total Allowed by Primary Carrier			*$88.20*
Total Paid by Primary Carrier			*$68.20*
Total allowed per Medicaid rate of $119.16 and patient balance liability is 20.00 per the member EOB.			$20.00 Copay - cannot be collected from the member since provider is billing Medicaid
The provider is entitled to their contracted rate with HFS of $119.16. $119.16 – $68.20 = $50.96 **Units** **Serv Code** **Billed** **Paid** **Allowed** **Adjustments** 1 HC:99202 $155.00 $68.20 $88.20 PR-2: $20.00 CO-45: $66.80			MCO should pay $50.96

Example 4

Provider is an independent practitioner with a contracted rate for Medicaid of $15.12

The provider will bill Medicaid after primary payor as follows:

Date of Service	Procedure Code	Place of Service	Line Charge
7/5/2019	99202	11	$155.00
Total Charge			$155.00
Total Paid if Medicaid was the Primary Payor			**$15.12**
Total Allowed by Primary Carrier			*$88.20*
Total Paid by Primary Carrier			*$68.20*
Total allowed by per Medicaid rate of $15.12 and patient balance liability is $20.00 per member EOB. Medicaid is less than what the provider was paid by the primary carrier.			$20.00 Cannot be collected from the member since provider is billing Medicaid
The provider is entitled to their contracted rate with HFS of $15.12 $15.12– $68.20 = 0.00 **Units** **Serv Code** **Billed** **Paid** **Allowed** **Adjustments** 1 HC:99202 $155.00 $68.20 $88.20 PR-2: $20.00 CO-45: $66.80			MCO should pay 0.00

Example 5

Provider is an independent practitioner with a contracted rate for Medicaid of $15.12

The provider will bill Medicaid after primary payor as follows:

Date of Service	Procedure Code	Place of Service	Line Charge
7/5/2019	99202	11	$155.00
Total Charge			$155.00
Total Paid if Medicaid was the Primary Payor			**$15.12**
Total Allowed by Primary Carrier 0 – $68.20 was applied to a 1000.00 deductible			*$0.00*
Total Paid by Primary Carrier 0.00			*$0.00*
Total allowed by per Medicaid rate of $15.12 per member EOB. Medicaid is less than what the provider was paid by the primary carrier. The provider is entitled to their contracted rate with HFS of $15.12 because deductible was applied. $15.12– .00 = 15.12			MCO should pay 15.12 because the cost was taken by their deductible.

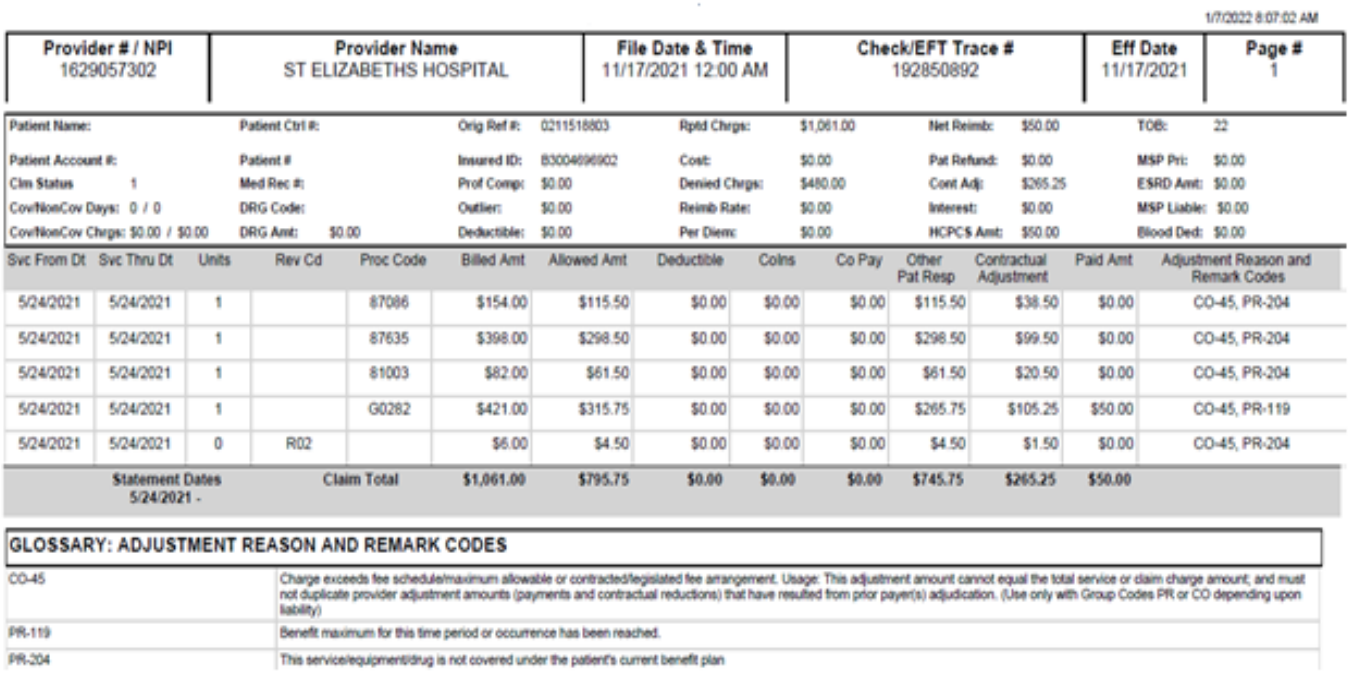
Institutional Providers

Example 1 – Hospital Claim

The Hospital contracted rate for Medicaid was $212.62 for this date of service. If a member has other insurance, MCO will only consider up to what Medicaid would allow.

Date of Service	Revenue Code	Procedure Code	Line Charge
5/24/2021	300	87086	$154.00
5/24/2021	300	87635	$398.00
5/24/2021	300	81003	$82.00
5/24/2021	240	G0282	$421.00
5/24/2021	942		$6.00
Total Charge			$ 1,061.00
Total Paid if Medicaid was the Primary Payor			**$212.62**
Total Allowed by Primary Carrier			*$745.75*
Total Paid by Primary Carrier			*$50.00*
Total allowed by per Medicaid rate of $212.62 The provider is entitled to their contracted rate with HFS of $212.62. $ 212.62 – $50.00 = $162.62			MCO should pay $162.62

Sample EOB



1/7/2022 8:07:02 AM

Provider # / NPI	Provider Name	File Date & Time	Check/EFT Trace #	Eff Date	Page #
1629057302	ST ELIZABETHS HOSPITAL	11/17/2021 12:00 AM	192850892	11/17/2021	1

Patient Name:		Patient Ctrl #:		Orig Ref #:	0211518803	Rptd Chrgs:	$1,061.00	Net Reimb:	$50.00	TOB:	22
Patient Account #:		Patient #		Insured ID:	B3004696902	Cost:	$0.00	Pat Refund:	$0.00	MSP Pri:	$0.00
Clm Status	1	Med Rec #:		Prof Comp:	$0.00	Denied Chrgs:	$480.00	Cont Adj:	$265.25	ESRD Amt:	$0.00
Cov/NonCov Days:	0 / 0	DRG Code:		Outlier:	$0.00	Reimb Rate:	$0.00	Interest:	$0.00	MSP Liable:	$0.00
Cov/NonCov Chrgs:	$0.00 / $0.00	DRG Amt:	$0.00	Deductible:	$0.00	Per Diem:	$0.00	HCPCS Amt:	$50.00	Blood Ded:	$0.00

Svc From Dt	Svc Thru Dt	Units	Rev Cd	Proc Code	Billed Amt	Allowed Amt	Deductible	Coins	Co Pay	Other Pat Resp	Contractual Adjustment	Paid Amt	Adjustment Reason and Remark Codes
5/24/2021	5/24/2021	1		87086	$154.00	$115.50	$0.00	$0.00	$0.00	$115.50	$38.50	$0.00	CO-45, PR-204
5/24/2021	5/24/2021	1		87635	$398.00	$298.50	$0.00	$0.00	$0.00	$298.50	$99.50	$0.00	CO-45, PR-204
5/24/2021	5/24/2021	1		81003	$82.00	$61.50	$0.00	$0.00	$0.00	$61.50	$20.50	$0.00	CO-45, PR-204
5/24/2021	5/24/2021	1		G0282	$421.00	$315.75	$0.00	$0.00	$0.00	$265.75	$105.25	$50.00	CO-45, PR-119
5/24/2021	5/24/2021	0	R02		$6.00	$4.50	$0.00	$0.00	$0.00	$4.50	$1.50	$0.00	CO-45, PR-204
	Statement Dates 5/24/2021 -			Claim Total	$1,061.00	$795.75	$0.00	$0.00	$0.00	$745.75	$265.25	$50.00	

GLOSSARY: ADJUSTMENT REASON AND REMARK CODES

CO-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)
PR-119	Benefit maximum for this time period or occurrence has been reached.
PR-204	This service/equipment/drug is not covered under the patient's current benefit plan

Example 2– Hospital Claim Example with deductible

The Hospital rate for Medicaid was $212.62 without other insurance for this date of service. If a member has other insurance, MCO will only consider up to what Medicaid would allow.

Date of Service	Revenue Code	Procedure Code	Line Charge
5/24/2021	300	87086	$154.00
5/24/2021	300	87635	$398.00
5/24/2021	300	81003	$82.00
5/24/2021	240	G0282	$421.00
5/24/2021	942		$6.00
Total Charge		$ 1,061.00	
Total Paid if Medicaid was the Primary Payor		**$212.62**	
Total Allowed by Primary Carrier		*$745.75*	
Total Paid by Primary Carrier = 0 – $745.75 was applied to a 1000.00 deductible		*$0.00*	
Total allowed by per Medicaid rate of $212.62 The provider is entitled to their contracted rate with HFS of $212.62. $ 212.62 – 0.00 = $212.62		MCO should pay $212.62	

Hospital Claims- Possible Differences when reviewing EOBs

It should be noted that there can be times that the primary payor's revenue codes may not exactly match with how Medicaid processes a particular service. There can be a discrepancy in billing based on the Illinois Medicaid Non Covered Revenue Code List (see Appendix H-3 of the HFS Handbook for Hospital Services). Many commercial payors are not going to have the same non-covered revenue codes as Illinois Medicaid. Those commercial primary payors are NOT going to deny a claim at the claim level as is done for Illinois Medicaid. Typically, the commercial payor would deny at the line level.

For example, for the primary payor a claim will include charges for non-covered revenue code services (examples 0637, 0771, 0385). Those charge lines will be populated on the primary payor's EOB.

When the claim is billed for secondary services to Illinois Medicaid, the providers will/may remove the non-covered revenue code service lines, which will show a reduction of the billed charges to what was billed to the primary payor. When this happens, the MCO should not deny the claim, but will validate the service dates, member details and calculate the difference of the charges that are on the claim against the EOB to ensure the correct EOB has been received. If the claim and EOB match (with the total charges discrepancy validated), the EOB should be used to adjudicate the claim.

Example 3 – Hospital Claim with Medicaid non-covered revenue codes.

Provide submits a claim for a $10,000.00 hospital bill to the Primary Payer

Statement From and Through Dates	Revenue Code	Line Charge
3/1/2022 – 3/5/2022	0120	$5,000.00
	0300	$500.00
	0320	$500.00
	0385	$500.00
	0440	$500.00
	0420	$1,000.00
	0360	$2,000.00
Total Charge **[Primary Pays everything but $50.00 copay**.]		$10,000.00

If there was no primary payor and this same claim was submitted to Illinois Medicaid:

- 0385 is on the HFS Non-Covered Revenue Code list.
- Line 0385 would cause the system to deny the claim back to the provider in full.
- MCOs cannot pay this claim with a non-covered revenue code because in the Illinois Encounter process, this claim will not be accepted at a claim level with this revenue code on the claim.
- The provider must submit a corrected claim removing the 0385-line charge for Illinois Medicaid claim processing.

Using the same mock EOB mock as above, see below for MCO claim submission:

Statement From and Through Dates	Revenue Code	Line Charge
3/1/2022 – 3/5/2022	0120	$5,000.00
	0300	$500.00
	0320	$500.00
	0440	$500.00
	0420	$1,000.00
	0360	$2,000.00
Total Charge **[Claim prices in APR DRG and calculates a price of $879.20.]**		$9,500.00

For this claim submission, the Medicaid MCO claim adjudicator would validate that the member, service dates and provider matches the EOB, and can deduce that the 0385 non-covered code was removed, accounting for the $500.00 difference in billed charges on the submission to the MCO plan.

Total Charge Primary Payor EOB	$10,000.00
Total Charge Claim Submission to Illinois Medicaid MCO	$9,500.00
Total Difference that can be attributed to the removal of non-covered revenue 0385	$500.00
Total Paid if Medicaid was the Primary Payor	**$879.20**
Total Allowed by Primary Carrier	$9,950.00
Total Paid by Primary Carrier	$9,950.00
Total allowed by Medicaid is $879.20 and patient balance liability is 50.00 copay from the primary carrier. $879.20 –$9,950.00 = 0 Since the primary paid over the Medicaid rate, there is no further payment due to the provider. A primary carrier co-pay cannot be collected from a Medicaid member.	0.00

Appendix M: HBIA/HBIS Populations

INTRODUCTION

NOTE: Per HFS notice, **the last date of medical coverage for members in the Health Benefits for Immigrant Adults (ages 42-64) will be June 30, 2025.** The Health Benefits for Seniors (ages 65+) will continue with no changes.

Effective 1/1/24, the Health Benefits for Immigrant Adults (HBIA) and the Health Benefits for Immigrant Seniors (HBIS) populations began transitioning from fee-for-service to managed care in four phases. This process will be essentially complete by April 1, 2024.

These populations can be identified through a 270/271 HIPAA standard EDI eligibility transaction (2110C EB05 in the 271 response) or **MEDI eligibiilty search** under the coverage detail tab showing the Case Types as follows:

Case Type: Immigrant Adults

Case Type: Immigrant Seniors

Information on Managed Care enrollment will also show in MEDI and the 270/271 EDI transaction; MCO Member ID cards will clearly indicate when a member is HBIA or HBIS.

Covered Services (mirror regular Medicaid with some exceptions)

- Doctor and hospital care
- Outpatient rehabilitative services such as physical and occupational therapy
- Kidney, bone marrow and stem cell transplant services
- Prescription drugs
- Lab tests
- Home health, mental health, and substance use services
- Post-acute rehabilitation care up to 90 days per episode*
- Dental, vision, and transportation services

** For post-acute rehab benefits occurring at Nursing Facilities, Hospitals, or Rehab Hospitals, authorization is always required. Please ensure that prior authorization is requested when a HBIA/HBIS member requires post-acute rehab services. Post-acute rehab at a nursing facility is only available to HBIA/HBIS enrollees in managed care.*

Covered services should be billed in accordance with billing guidance for the general Medicaid population, as described in this manual, and consistent with prior authorization requirements per each MCO.

Non-Covered Services

- Long-term care
- Home and community-based services (HCBS waiver services)
  Transplant services (**exception:** kidney, bone marrow and stem cell transplant services; see above "Covered Services")

CO-PAYMENTS and COINSURANCE (*Cost-sharing*)

Per HFS rules, the HBIA/HBIS populations are subject to co-payments and coinsurance for certain services billed by a hospital or Ambulatory Surgical Treatment Center (ASTC) on a UB –04 or 837I claim form. Any services billed by a provider on an 837P claim form using a provider's NPI, is **not** subject to a 10% coinsurance, even if performed in a hospital setting.

Where cost sharing is permissable, the amount paid to the hospital will be reduced by the amount of the co-payment or coinsurance.

Hospitals and ASTCs may collect the following co-payments and coinsurance, unless the MCO has chosen to waiver cost-sharing on the below services:[1]

Service	Cost-Sharing
Non-emergency inpatient hospitalization	$250 co-payment
Hospital Outpatient Services and ASTC services	10% of HFS reimbursement rate (coinsurance)

Non-emergent Inpatient Hospitalization Claims

A claim must meet the following requirements to collect a $250 copayment:

1. Priority Type of Admission is 2 = Urgent or 3 = Elective (if 1 = Emergency, no co-pay**)
2. Provider bills service with an NPI registered as one of the below Categories of Service (COS) in the HFS Provider IMPACT system and bills on an 837I claim form:
    - COS 020 Inpatient Hospital Services (General)
    - COS 021 Inpatient Hospital Services (Psychiatric)
    - COS 022 Inpatient Hospital Services (Physical Rehabilitation)
3. Member is in the HBIA or HBIS population in MEDI.

** Inpatient hospitalizations that result from an ER visit should be considered a Priority Type of Admission 1 (emergency) which means no copayment should be charged.

Hospital Outpatient Services

A claim must meet the following requirements to collect 10% coinsurance on the amount Medicaid would pay:

1. Priority Type of Admission is 2 = Urgent or 3 = Elective (if 1 = Emergency, there is no coinsurance)
2. Provider bills service with an NPI registered as one of the below Outpatient Categories of Service (COS) in the HFS Provider IMPACT system and bills on an 837I claim form:
    - COS 024 – Surgical Services (General)
    - COS 024 Diagnostic and therapeutic services
    - COS 024 – Observation services
    - COS 027 and COS 28 – Psychiatric treatment services
    - COS 029 – PT, OT or ST

NOTE: Dialysis in a hospital outpatient setting (COS 25) is excluded from any coinsurance requirement.

3. Member is in the HBIA or HBIS population in MEDI.

[1] Check Member ID card for applicable co-pays/co-insurance as it may vary between MCO.

ASTC (Ambulatory Surgical Treatment Centers) Services

Services performed at an ASTC are not considered emergent and therefore, ASTCs may collect coinsurance for any surgery that meets the above requirements. The coinsurance charged can be no more than 10% of the Medicaid reimbursement based on the final EAPG pricing. HFS and the MCOs will deduct the copay amount from the ASTC's payment, unless the MCO has chosen to waive the cost-sharing.

As with the hospital outpatient service, any service billed on an 837P in a provider's name and NPI does not have a coinsurance payment, regardless of where the service is performed.

POST-ACUTE SHORT TERM REHABILITATION STAYS

HBIA/S members are eligible for up to 90 days of post-acute short-term rehabilitation care at skilled nursing facilities, rehabilitation hospitals or in a distinct rehab/skilled unit of a hospital. All post-acute short-term stays require prior authorization. Admission to a skilled nursing facility, including a short-term rehab, requires member to have a background check, Determination of Need (DON) and PASRR screen. Social Security Numbers (SSNs) are not required for a PASRR screen or background check. Hospitals or surgical treatment centers should follow the normal process of scheduling a background check and PASRR screen.

Custodial care is not a covered benefit and will not be reimbursed.

HBIA/HBIS customers who receive rehabilitation services in a skilled nursing facility will not be entered as an admission in MEDI or have a group care credit (GCC). Members do not have any patient credit responsibilities and **will not show up** on the Patient Credit File (PCF). There is no co-payment.

For those HBIA/HBIS customers who receive rehabilitation services in a rehabilitation hospital, or a distinct rehab/skilled unit of a hospital will have a $250 co-payment, unless the MCO has waived cost sharing. **Do not contact HFS' Bureau of Long-Term Care or DHS regarding these members.**

Claim requirements:

Provider Type	Required Category of Service (COS)	Taxonomy Codes	Revenue Codes	Bill Types
PT 033 (Nursing Facility)	070 or 071	314000000X	0118, 0128, 0138, 0148, 0158	021X or 022X
PT 032 (Rehab Hospital)	022	273Y00000X Rehabilitation Unit 283X00000X Rehabilitation Hospital	0118, 0128, 0138, 0148, 0158	011X or 012X
PT 030 (General Acute Care Hospital)	022	273Y00000X Rehabilitation Unit 283X00000X Rehabilitation Hospital	0118, 0128, 0138, 0148, 0158	011X or 012X

- Leave of Absences (LOA) Revenue Codes 0183 and 0185 are allowable (excludes Patient Convenience 0182), but LOAs do not restart the 90-day benefit period. These codes are not allowable for rehabilitation hospitals or distinct rehab/skilled units of hospitals.
- Value code 80 must equal covered days

- Value Code 81 must equal non-covered days (LOAs)
- All standard ORP requirements apply
- Claims can be billed in monthly increments, but expect most stays are shorter than 30 days. Refer to the interim billing guidelines in the Inpatient Hospital section of this manual.
- Payment is made on a per-diem basis
- Vent care is considered skilled care and is not covered
- SNF DME oxygen is covered and should be billed in the normal fashion for Illinois Medicaid.