The purpose of this update is to outline policy and procedure billing changes for HCBS Waiver providers.

The billing guidance will REPLACE any previously issued billing guidance for these providers for any claims received starting 11/1/2020. Providers should continue billing MCOs with current practices until that time. The guidance can be found on the following pages.
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:

Persons who are Elderly- Elderly Waiver:
The Illinois Department on Aging (IDoA) operates this waiver population for person age 60 or older, who are otherwise eligible for or at risk for nursing facility care as evidenced by a DON.

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, and eligible for or at risk for nursing facility care as evidenced by the DON.

Person with HIV or AIDS Waiver:
DRS administers this waiver population for persons of any age diagnosed with HIV or AIDS who are at risk of hospital or nursing facility care as evidenced by the DON.

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.
Supportive Living Program - SLP Waiver:
The Illinois Department of Healthcare and Family Services (HFS) operates this waiver population for persons ages 65 and older, or persons with disabilities (as determined by the Social Security Administration) age 22 and older. Individuals have been screened by HFS and found to be in need of nursing facility level of care and it is determined that a SLF is appropriate to meet the needs of the individual. Individuals must not have a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. Finally, an individual's income must be equal to or greater than current SSI and they must contribute all but $90 toward lodging, meals, and services. Food stamp benefits may be used toward meal costs.

Note: Refer to the IAMHP Billing Manual section for 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:

<table>
<thead>
<tr>
<th>HFS Provider Type</th>
<th>HFS Description</th>
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<tbody>
<tr>
<td>090</td>
<td>Waiver service provider--Elderly (IDoA)</td>
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<tr>
<td>092</td>
<td>Waiver service provider--Disability (DHS/DRS)</td>
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<tr>
<td>093</td>
<td>Waiver service provider--HIV/AIDS (DHS/DRS)</td>
</tr>
<tr>
<td>098</td>
<td>Waiver service provider--TBI (DHS/DRS)</td>
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</table>

To file a claim for services that an MCO has approved for one of the five HCBS waivers described above, waiver providers are required to register as a Waiver provider with IMPACT. Many HCBS providers are considered ‘atypical’ by HFS’ IMPACT system. HFS IMPACT Definition of an ‘Atypical’ provider is:

A provider who is delivering services to Medicaid clients that are not considered to be health care services. These providers are not required to obtain an NPI (National Provider Identifier). The Centers for Medicare and Medicaid Services (CMS) defines Atypical Providers as providers that do not provide health care. This is further defined under HIPAA in Federal regulations at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of Atypical Providers reimbursed by the Medicaid program. Even if these Atypical Providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and should not receive an NPI number.

When billing HCBS services, the provider should only use their HFS’ Legacy Provider Number (Medicaid ID) and should NOT send in an NPI on the claim.

MCOs will require that the HFS’ Legacy Provider Number (Medicaid ID) on the claim matches the IMPACT Legacy Provider Number (Medicaid ID). MCOs will not process the claim if the Legacy Provider Number (Medicaid ID) used does not match the corresponding HFS’ Legacy Provider Number (Medicaid ID) and IMPACT-registered categories of service, specialties etc. The provider’s HFS Legacy Provider Number (Medicaid ID) must match the
IMPACT-registered provider type that corresponds with the member’s waiver type. For example, an HFS’ Legacy Provider Number (Medicaid ID) registered as provider type 090: Waiver service provider—Elderly should not be billed on a claim for a member who has a TBI waiver.

A valid Medicaid ID must be on the 837P Billing Provider Secondary Identification Loop 2010BB Loop in a REF01 Segment qualified by ‘G2’ and the REF02 equal to the provider’s Medicaid ID as registered in IMPACT for their respective waiver provider type.

If the provider has multiple registrations with HFS for provider types outside of the HCBS service realm, the provider should ONLY bill their NPI on the claim for NON-HCBS services.

For example, if the provider is registered as an HFS Home Health provider type (050) and registered as a HCBS service provider (090), when billing for Home Health services the provider will bill on an 837I and must use their NPI in the 2010AA Billing Loop on the 837I. When billing as HCBS with HFS provider type 090, the claim must be on an 837P and the provider must submit their Medicaid ID without an NPI.

**Personal Assistants and Individual Providers**

The MCO’s work in collaboration with the member to develop an individualized care plan that may include personal assistants. The MCO’s will provide care coordination and oversight of the services being provided to the member. Personal Assistants (PA’s) and Individual Providers (IP’s) that are not working through an agency are required to enroll in IMPACT. When seeking reimbursement, PA and IP’s will not submit claims directly to the MCO’s. They will be required to log their time using the electronic visit verification system and from there, the payment will be issued by the State of Illinois.

**Categories of Service (COS) and Specialties**

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

<table>
<thead>
<tr>
<th>HFS Legacy Category of Service</th>
<th>IMPACT Subspecialty</th>
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<tbody>
<tr>
<td>090</td>
<td>Case Management</td>
</tr>
<tr>
<td>091</td>
<td>Home Maker</td>
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<tr>
<td>092</td>
<td>Agency Providers PA, RN, LPN, CAN and Therapist</td>
</tr>
<tr>
<td>093</td>
<td>Individual Providers PA, RN, LPN, CAN and Therapist</td>
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<tr>
<td>094</td>
<td>Adult Day Service</td>
</tr>
<tr>
<td>095</td>
<td>Habilitation Services</td>
</tr>
<tr>
<td>096</td>
<td>Respite care</td>
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<tr>
<td>097</td>
<td>Other HCFA approved services</td>
</tr>
<tr>
<td>098</td>
<td>Electronic Home Response/EHR installation</td>
</tr>
</tbody>
</table>
Diagram -

Example 1: Provider who is registered in IMPACT as both a Home Health Provider and as a Waiver Provider

Home Health and Homemaker

Medical Services Bill with NPI
  Bill Home Health on an Institutional claim form
  Claim will adjudicate as medical claim and follow all medical processing guidelines
  Claim will be validating for an Ordering/Referring provider in addition to the attending provider on Institutional claims

Is this an HCBS waiver service?
  NO
    Bill Home Health on an Institutional claim form
    Claim will adjudicate as medical claim and follow all medical processing guidelines

  YES
    HCBS Waiver Services Bill with Medicaid ID
    Member waiver
      Aging PT = 90
      Physical Disability PT = 92
      HIV/AIDS PT = 93
      TBI PT = 98
      Must bill Medicaid ID = Waiver services of Member
      Bill claim on a Professional claim form
      Claim will process as a waiver claim and will follow all waiver guidelines and requirements
      Waiver services are excluded from ORP requirements
Example 2: Provider who is registered in IMPACT as a DME Provider and a Waiver Provider
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 on in the IAMHP Comprehensive Billing Guide.

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

<table>
<thead>
<tr>
<th>HCSB Service</th>
<th>HCPC Procedure Code</th>
<th>Modifier</th>
<th>Unit Value Definition</th>
<th>Allowable Place of Service</th>
<th>Elderly Waiver HFS Provider Type: 90</th>
<th>Disability Waiver HFS Provider Type: 92</th>
<th>HIV/AIDS Waiver HFS Provider Type: 93</th>
<th>Traumatic Brain Injury Waiver HFS Provider Type: 98</th>
<th>HFS Category of Service/Subspecialty</th>
<th>Acceptable Taxonomies</th>
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<td>HCSB Service</td>
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<td>Modifier</td>
<td>Unit Value Definition</td>
<td>Allowable Place of Service</td>
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<td>Supported Employment No Job Coach Individual</td>
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<td>Home Modification</td>
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<td>HCSB Service</td>
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<td>Modifier</td>
<td>Unit Value Definition</td>
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<td>Speech Therapy</td>
<td>G0153</td>
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<td>Per visit with a 4 hours max</td>
<td>11, 12</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>2352000000X--Speech Therapist</td>
</tr>
<tr>
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<td></td>
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<td>251E000000X--Home Health</td>
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<tr>
<td>Speech Therapy-Services delivered under an outpatient hospital speech language pathology plan of care</td>
<td>G0153 GN</td>
<td></td>
<td>Per visit</td>
<td>11, 19, 22</td>
<td>Y</td>
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<td>2352000000X--Speech Therapist</td>
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<td>282N000000X--General Acute Hospital</td>
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<tr>
<td>Home Delivered Meals</td>
<td>S5170</td>
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<td>2 meals = 1 unit Maximum = 1 unit per day</td>
<td>12, 99</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>332U000000X--Home Delivered Meals</td>
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<tr>
<td>Personal Emergency Response Install</td>
<td>S5160</td>
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<td>Per Install</td>
<td>12, 99</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Y</td>
<td>146D000000X--Personal Emergency Attendant</td>
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<td>3333000000X--Emergency Response System</td>
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<tr>
<td>Personal Emergency Response Monthly</td>
<td>S5161*</td>
<td>*</td>
<td>Per Month</td>
<td>12, 99</td>
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<td>Y</td>
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<td>146D0000000X--Personal Emergency Attendant</td>
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<tr>
<td>Automatic Medication Dispenser</td>
<td>A9901</td>
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<td>Per Install</td>
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<td></td>
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<td>332B000000X--Medical Equipment &amp; Medical Supplies</td>
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<tr>
<td>Automatic Medication Dispenser Monthly</td>
<td>T1505</td>
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<td>Per Month</td>
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<td></td>
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<td>332B000000X--Medical Equipment &amp; Medical Supplies</td>
</tr>
</tbody>
</table>

*Exception for Molina: When services are provided on a cellular platform vs. a landline, S5161 should include the U2 modifier.
**837P Submission Guidelines:**

<table>
<thead>
<tr>
<th>Paper Claim CMS-1500</th>
<th>HIPAA 5010 837P Loop</th>
<th>HIPAA 5010 837P Segment</th>
<th>Waiver Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Box 24b</td>
<td>2300</td>
<td>CLM05-1</td>
<td>Place of Service Code</td>
</tr>
<tr>
<td>Box 24f</td>
<td>2400</td>
<td>SV1-02</td>
<td>Appropriate procedure code as indicated in the coding grid above</td>
</tr>
<tr>
<td>Box 24j</td>
<td>2310B</td>
<td>NM1-09</td>
<td>Should not submit</td>
</tr>
<tr>
<td>Box 31</td>
<td>DOES NOT MAP IN THE 837</td>
<td>DOES NOT MAP IN THE 837</td>
<td></td>
</tr>
<tr>
<td>Box 32</td>
<td>2310C</td>
<td>NM1</td>
<td>Service Facility Location Information</td>
</tr>
<tr>
<td>Box 33</td>
<td>2010AA</td>
<td>Do not send NPI in NM109 – See 2010BB Loop below</td>
<td>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)</td>
</tr>
<tr>
<td>Box 33B</td>
<td>2010BB</td>
<td>REF02 = G2 REF03 = Provider’s HFS Medicaid ID</td>
<td>HFS Medicaid ID for provider Example 2010BB example: REF<em>G2</em>Provider HFS Medicaid ID Paper Example</td>
</tr>
<tr>
<td>Pay to Provider No field for this on CMS 1500</td>
<td>2010AB</td>
<td>NM1*87</td>
<td>Pay to Provider Address (P.O. Box or Lock Boxes acceptable in this loop) **</td>
</tr>
</tbody>
</table>

**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.