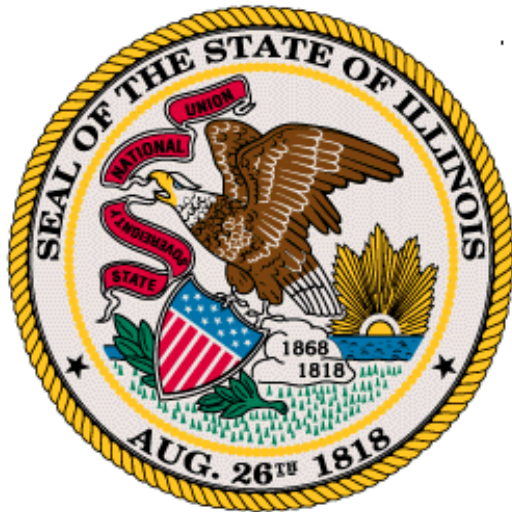


Illinois Department of Healthcare and Family Services

Physician Billing Webinar

September 10, 2014



What's New at HFS?

- New links on the HFS Medical Programs website at <http://www2.illinois.gov/hfs/MedicalPrograms/Pages/default.aspx>
 - **Claims Processing System Issues** will provide you with the most current system issues the Department is experiencing, as well as information regarding resolutions. This link may be found on the website at: <http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx>

Providers are encouraged to review this site for possible explanation to their billing questions or issues before contacting a billing consultant
 - **Non-Institutional Providers Resources** is designed to assist Non-Institutional Providers with HFS billing and payment for services, as well as provide answers to frequently asked questions and links to webinar slides. This link may be found on the website at: <http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx>
- Family Planning
- Senate Bill 741
- Tobacco Cessation Coverage

Family Planning Changes

Dispensing Fee

- Effective July 1, 2014 the dispensing fee for family planning methods purchased through the 340B federal Drug Pricing Program increased to \$35.00
- Providers must identify 340B purchased drugs by reporting modifier “UD” in conjunction with the appropriate procedure code
- The provider charge should be the actual acquisition cost plus the \$35 dispensing fee
- A provider release with details regarding this change is forthcoming

Family Planning Changes (con't)

Vaginal Ring, Contraceptive Patch and Oral Contraceptives

- Providers must dispense the three (3) month supply allowable by the Department whenever possible
- Exceptions may be made when medically contraindicated and documented in the patient's medical record
- Please ensure medical records document the reason for **NOT** dispensing the required three (3) month supply

Family Planning Changes (con't)

Emergency Contraceptive Pills

- HFS has updated the dispensing policy of emergency contraception allowing for advance provision of up to three (3) doses if clinically indicated
- Effective July 1, 2014 the Department will no longer reimburse emergency contraceptive pills billed with procedure code J8499
- All emergency contraceptive pills must be billed using procedure code S4993 effective July 1, 2014

Family Planning Changes (con't)

Adjustments

- For dates of service prior to July 1, 2014:
 - Providers who billed in accordance with the April 24, 2013 provider notice and did not add the \$20 dispensing fee in the charge amount did not receive the dispensing fee
 - In order to receive the correct payment for the 340B drug with the \$20.00 dispensing fee, providers should submit replacement claims or complete void/re-bill transactions to reflect a single charge which includes the actual acquisition cost plus the \$20 dispensing fee

- For dates of service on/after July 1, 2014:
 - Providers who billed EC with procedure code J8499 for dates of service on or after July 1, 2014 should submit replacement claims using procedure code S4993
 - Providers who billed at the actual acquisition cost plus the previous \$20.00 dispensing fee should submit replacement claims for reimbursement of the increased dispensing fee

- The department will work with providers on an individual basis as needed to ensure claims are properly adjusted to reimburse the correct dispensing fee

Senate Bill 741

Medicaid Benefit Changes

- Details may be found on the HFS website at <http://www2.illinois.gov/hfs/agency/pages/sb741factsheet.aspx>
- Restoration of coverage for dental care services for adults to that prior to the SMART Act effective July 1, 2014
- Restoration of coverage for podiatry services for adults effective October 1, 2014. Coverage for podiatry services for adults is no longer limited to participants with a primary diagnosis of diabetes.
- Elimination of the prior authorization requirement under the four prescription policy for anti-psychotic drugs effective July 1, 2014
- Elimination of the prior authorization requirement under the four prescription policy for children with complex medical needs who are enrolled in CCE solely to coordinate care for these children, if the CCE has a comprehensive drug reconciliation program, effective July 1, 2014
- Elimination of the annual 20 visit limit for speech, occupational and physical therapies effective October 1, 2014
- Prior approval will be required for all participants for speech, occupational and physical therapies (effective date to be announced)

Update to Adult Dental Coverage

- Please refer to the June 26, 2014 Informational notice at:
<http://www.hfs.illinois.gov/assets/062714n.pdf>
- Effective July 1, 2014, coverage for adult dental services will be restored to that prior to the SMART Act
- Pregnant women (prior to the birth of their children) are eligible for the following five preventive dental services in addition to the dental benefits listed for all eligible adults:
 - Periodic Oral Evaluation
 - Cleaning
 - Periodontal Scaling and Root Planing-4 or more teeth per quadrant
 - Periodontal Scaling and Root Planing-1-3 teeth per quadrant
 - Full Mouth Debridement

Tobacco Cessation Counseling Services

- Please refer to the provider notice dated August 26, 2014 at:
<http://www.hfs.illinois.gov/assets/082614n.pdf>
- Effective with dates of service on and after January 1, 2014 the Department will reimburse providers for tobacco cessation counseling services rendered to pregnant and post-partum women age 21 and over, as well as children through age 20, in accordance with the Affordable Care Act
- Tobacco cessation counseling services for the above populations may be a separately billable service under the following procedure codes:
 - 99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
 - 99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
- Counseling sessions must be provided by, or under the supervision of, a physician or any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services

Tobacco Cessation Counseling Services (con't)

Duration of Counseling

- For pregnant and up to 60-day post-partum women age 21 and over
 - A maximum of three quit attempts per calendar year
 - Up to four individual face-to-face counseling sessions per quit attempt
 - The 12 maximum counseling sessions include any combination of the two procedure codes identified in the previous slide
- Children through age 20 are not restricted to the maximum twelve counseling sessions

Tobacco Cessation Counseling Services (con't)

Pharmacotherapy

- The Department covers nicotine replacement therapy in multiple forms, as well as two prescription medications indicated for use as an aid to smoking cessation
- Please refer to the Drug Prior Approval webpage for specific drug coverage and prior approval requirements. This link may be found at:
<http://ilpriorauth.com/>
- Nicotine replacement duration of therapy is normally limited to three months in a year; however, duration limitations may be overridden by the department through the prior approval process on an individual patient basis
- To request prior approval for a specific drug please refer to the link at:
<http://www.hfs.illinois.gov/pharmacy/prior.html>

Reminder: Annual Medical Cards

- Please refer to the provider notice dated January 30, 2013 at:
<http://www.hfs.illinois.gov/assets/013013n.pdf>
- *Providers should verify medical eligibility at each visit or risk non-payment*
- Providers may not charge participants to verify eligibility
- If the individual provides a Medical Card, Recipient Identification Number (RIN), or Social Security number and date of birth, providers may verify eligibility through one of the following resources:
 - MEDI Internet site at: <http://www.myhfs.illinois.gov/>
when using MEDI be sure to scroll down to view possible MCO enrollment
 - The REV system. A list of vendors is available at:
<http://www2.illinois.gov/hfs/MedicalProvider/rev/Pages/default.aspx>
 - The Automated Voice Response System (AVRS) at 1-800-842-1461

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

- Please refer to the March 4, 2013 provider notice at:
<http://www.hfs.illinois.gov/assets/030413n.pdf>
- For dates of service January 1, 2013 through December 31, 2014, HFS will apply an increased payment rate to eligible, enrolled providers for primary care services, including vaccines
- Increased payments will apply to services reimbursed by Medicaid fee-for-service, or through the MCOs and ICPs
- For providers identified as eligible, increased rates will be paid as an “add-on” to the qualified procedure codes through an adjustment process. *The adjustment will be paid separately from the service.*

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

Provider Attestation

- Providers defined as eligible for these increased rates must meet criteria as stated in the March 4, 2013 notice (link in the previous slide)
- Physicians must self attest they meet at least one of the criteria. The HFS 2352 Certification and Attestation form is available on the provider enrollment webpage at <http://www.hfs.illinois.gov/enrollment/>

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

APNs and ACA payments

- Please refer to the July 29, 2013 provider notice at <http://www.hfs.illinois.gov/assets/072913n.pdf> for details and billing instructions
- Services performed by APNs under the personal supervision of an eligible physician who assumes professional responsibility and legal liability for those services will be reimbursed at the increased rate for primary care services
- Services must be submitted under the NPI of the eligible, supervising physician as the rendering provider
- Modifier “SA” must be entered into the modifier field for each procedure code

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

Allowable CPT Codes

- The ACA fee schedule for primary care services may be viewed at:
<http://www2.illinois.gov/hfs/SiteCollectionDocuments/ACAEMFeeSchedule010114.pdf>
- The ACA fee schedule for vaccines may be viewed at:
<http://www2.illinois.gov/hfs/SiteCollectionDocuments/ACAVaccineFeeSchedule020114.pdf>
- The increased payment will be the difference between the lesser of the maximum allowed amount or the provider charge minus any TPL, co-pay, or HFS paid amount on the original claim

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

Allowable Vaccine CPT Codes and Charges

- HFS does not pay for the vaccine product itself. Reimbursement is for the administration of vaccines distributed to VFC enrolled providers, *although providers must bill using the CPT code for the specific vaccine product*. Vaccine billing instructions are detailed in Appendix A-8 of the Chapter 200 handbook at <http://www.hfs.illinois.gov/assets/a200a.pdf>. Clarification of policy was also posted in the September 30, 2013 provider notice at <http://www.hfs.illinois.gov/assets/093013n.pdf>.
- *Providers are reminded to bill the Department their usual and customary charge amount for the appropriate vaccine administration service CPT*. Reimbursement on the original claim for the VFC vaccine administrative service is \$6.40. The Medicare maximum allowed amount per vaccine will be \$23.87
- Providers eligible for the ACA adjustment who did not receive the full adjustment up to the Medicare allowable rate because they did not bill their U & C charge for the vaccine administration code may submit a replacement claim with their U & C as the charge amount. By replacing the original DCN, both the initial payment and the ACA adjustment will be voided. The replacement claim will then be identified for ACA adjustment at a later date.

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

Electronic Remittance Advice

- 835s reporting the ACA payments will *only* contain information regarding those payments
- The ACA payments will be processed as adjustments to the original service
- When referring to the Remittance Advice Instructions on MEDI, please refer to page 16 for information regarding adjustments
- When viewing 835 raw data:
 - the first CLP segment will provide information about the original service to which the adjustment applies, including the original DCN and the original amount paid. The original amount paid will be a negative number, but this does *not* reflect a recoupment:

CLP*003569105*22*-235*-66.4MC*20131232212345601*B~ (DCN of original payment/claim)**

- The second CLP segment will show the same amount with a positive number for the purpose of balancing the segments:

CLP*003569105*1*235*66.4MC*20131222244556601*B~ (DCN of the adjustment/ACA payment)**

- The PLB segment will then show the 22D adjustment/add-on amount and DCN for that adjustment. This amount will be a negative number but reflects the additional payment to the provider:

PLB*036080157*20131231*CS:22D22153756620131222244556601*-99.88~

(DCN matches DCN in 2nd CLP segment)

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

Paper Remittance Advice

- Adjustment process type will be “22D”
- Reason/remark code will be “3313 – ACA PCP payment”
- The same process type and reason/remark code will be used for the additional adjustment being generated to correct the vaccine underpayment
- Amount billed & allowed amount will be the adjustment amount reflecting the additional payment
- Status DB (debit)
- DCN will be the adjustment DCN
- The paper remit will not provide the original DCN to which the adjustment applies, but will include the RIN, procedure code and date of the original service

Affordable Care Act (ACA)

Increased Payment for Primary Care Services

Adjustments with Reason Code 3314

- Informational Message “**Annual ACA Rate Change**” – adjustments will correct underpayments or overpayments to reflect 2014 rate changes that were established after increased payments had already been completed for 2014 claims at 2013 rates
- Informational Message “**HFS Calculation Error**” – adjustments will correct a Department calculation error that affected some claims and resulted in either an underpayment or overpayment of the ACA increased rate
- Informational message “**ACA PCP Pmt Void**” – adjustments will recoup the increased payment when the provider has initiated a void of the original claim

Adjustments with Reason Code 3317

- Informational message “**ACA Pmt Recoup/Client Category Ineligible**” – adjustments will correct payments to providers for Title 21 (state-funded) participant eligibility categories for which increased payments did not apply ; Adjustments to recoup these payments have been completed per the April 14, 2014 notice at <http://www.hfs.illinois.gov/assets/041414n2.pdf>

Home Health Care Services

➤ **Face-To-Face Requirement**

- As a result of the SMART Act effective with dates of service beginning January 1, 2014 the Department will require that the initial certification of Home Health intermittent skilled nursing services and/or therapy services include documentation that a face-to-face encounter was conducted by the practitioner ordering the home health services
- Please refer to the December 11, 2013 provider notice at <http://www.hfs.illinois.gov/assets/121113n.pdf> for further information and details regarding the conditions that must be met during the face-to-face encounter

➤ **Rate Change**

- As a result of Senate Bill 741, the Department will increase the rates paid to Home Health Agencies for all-inclusive intermittent visits, and for In-Home shift hourly nursing services rendered by a Certified Nursing Assistant (CNA), effective July 1, 2014
- A provider release announcing these rate changes is forthcoming. Rate changes will also be reflected on the updated home health fee schedule.

Four Prescription Policy

- As a result of the SMART Act, HFS has reduced the number of prescriptions that can be filled in a thirty-day period, without prior authorization, to four. Information regarding this policy is posted on the web site at <http://www.hfs.illinois.gov/pharmacy/script/>
- Exceptions to the prescription policy will be allowed in certain situations, with prior approval. As a reminder, effective July 1, 2014 Senate Bill 741 eliminated the prior authorization requirement anti-psychotic drugs and for children with complex medical needs enrolled in a CCE solely to coordinate their care.
- A prior approval request for exception can be initiated electronically on the MEDI system. Please refer to the September 4, 2012 informational notice entitled Drug Prior Approval/Refill Too Soon Entry System), posted on the web site at <http://www.hfs.illinois.gov/assets/090412n1.pdf>
- Effective with the December 10, 2013 provider notice at <http://www.hfs.illinois.gov/assets/121013n.pdf>, the Department will not require prior approval or four prescription policy overrides for anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder according to department records

Changes to Illinois Hemophilia Program

- As a result of the SMART Act effective with dates of service on or after September 1, 2012, HFS began reimbursing services provided to participants in the Illinois Hemophilia Program at the Department's standard reimbursement rates
- As a result, services were no longer reimbursed at the provider's billed charges
- The Illinois Hemophilia Program no longer offers additional coverage for primary care physician visits to qualifying participants due to cancellation of the federal waiver program
- As a result of the Affordable Care Act effective January 1, 2014 a patient's primary insurance may begin to cover the costs currently covered through the State Hemophilia Program. In accordance with Public Act 98-0104, patients must meet their obligations under ACA and may be required to obtain and provide proof of health coverage to the department. Payment of a tax penalty for not obtaining insurance does not meet the requirement. **The department has notified current participants by letter regarding changes.** Please refer to the December 27, 2013 provider notice at <http://www.hfs.illinois.gov/assets/122713n.pdf> for more information and a provider contact number.

Sexual Assault Emergency Treatment Program

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS will reimburse services provided to survivors of a sexual assault through the Sexual Assault Emergency Treatment Program at the Department's standard reimbursement rates, including follow-up care
- For details and billing instructions please refer to the June 29, 2012 provider release at: <http://www.hfs.illinois.gov/assets/062912n2.pdf>
- Hospitals must register all non-Medicaid sexual assault patients in the MEDI Early Registration of Sexual Assault Survivor's System and issue follow-up Authorization for Payment Vouchers for direct payment to service providers - all providers should include a copy of this authorization with their claim

Services to Hospice-Enrolled Participants

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, some services will no longer be covered for non-hospice providers serving patients enrolled in the Department's hospice program
- These restrictions do not apply to Medicare recipients or participants under age 21 years
- For details and a complete list of non-covered services please refer to the June 27, 2012 provider notice at:
<http://www.hfs.illinois.gov/assets/062712n3.pdf>
- These restrictions do not affect services provided and billed by the hospice agency
- Exception: Physician and APN services will be reimbursed only if the service is not related to the terminal illness, identified on a claim by applying the GW modifier to the procedure code

Chiropractic Services

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS has eliminated chiropractic services for participants 21 years of age and older
- For details please refer to the June 30, 2012 provider notice at:
<http://www.hfs.illinois.gov/assets/063012n.pdf>
- Participants under the age of 21 will continue to receive coverage for spinal manipulation procedures to correct subluxations of the spine only
- Claims for participants under the age of 21 must include a diagnosis of spinal subluxation at the applicable level and an allowable procedure code from the Chiropractic Fee Schedule located at
<http://www.hfs.illinois.gov/assets/070112chiro.pdf>

Group Psychotherapy

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS has eliminated coverage of group psychotherapy for participants who are residents in a nursing facility, including a nursing facility classified as an institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act
- For details please refer to the provider notice at:
<http://www.hfs.illinois.gov/assets/062712n1.pdf>
- Per the July 23, 2012 addendum to the June 27, 2012 provider notice, the procedure codes affected by this change are 90853 and 90849. The July 23, 2012 addendum may be viewed at
<http://www.hfs.illinois.gov/assets/072312n1.pdf>.

Prior Approval for Surgeries for Morbid Obesity

- As a result of the SMART Act effective with dates of service on or after October 1, 2012 prior approval is required for surgery for morbid obesity
- The prior approval requirement includes assistant surgeons
- For details and instructions regarding submission of prior approval requests please refer to the provider notice at:
<http://www.hfs.illinois.gov/assets/091112n.pdf>
- Prior approval requests must be submitted on Form HFS 1409, Prior Approval Request, along with supporting documentation as explained in the September 11, 2012 provider notice
- The Practitioner Fee Schedule specifies procedure codes requiring prior approval

340B Purchased Drugs

- Section 340B of the Public Health Service Act limits the cost of covered outpatient drugs to certain federal grantees, FQHC look-alikes, and qualified hospitals. These providers purchase pharmaceuticals at significantly discounted prices. Such providers enrolled with the US Department of Health and Human Resources Administration are considered 340B providers.
- Registration for the program is completed through the Office of Pharmacy Affairs, 1-800-628-6297.
- As a result of the SMART Act effective July 1, 2012, providers enrolled with HFS as a provider type other than pharmacy who are submitting fee-for-service claims for 340B purchased drugs must charge HFS no more than their actual acquisition cost for the drug product

\$12 Dispensing Fee for 340B Purchased Drugs

- Effective for dates of service on or after February 1, 2013, a \$12.00 dispensing fee add-on will apply to other generic and brand name drugs purchased through the 340B program. The April 15, 2013 provider notice posted on the web site at <http://www.hfs.illinois.gov/assets/041513n.pdf> instructs providers to identify such drugs by modifying the procedure code with “UD” and to include the \$12.00 dispensing fee in the total charges. Providers who failed to include the dispensing fee as outlined in this notice may submit a replacement claim.
- Reimbursement for 340B purchased drugs will be the lesser of the actual acquisition for the drug, as billed by the provider, or the Department’s established 340B allowable reimbursement rate for the drug, plus the applicable dispensing fee.

Provider Rate Reductions

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, reimbursement rates paid to certain providers were reduced by 2.7%
- For details please refer to the provider notice at:
<http://www.hfs.illinois.gov/assets/071712n1.pdf>
- Providers exempt from the rate reduction include:
 - Physicians
 - Optometrists (medical visits)
 - Dentists
 - APNs
 - Community Mental Health Providers
 - FQHCs, RHCs, and ERCs
 - Local Education Agencies (LEAs)
 - DORs Schools
 - School-based clinics
 - Local Health Departments
 - Hospice agencies
 - Early Intervention
 - Emergency-related transportation
 - Home Health Intermittent Skilled Visits (effective July 1, 2014 as a result of Senate Bill 741)
- The rate reductions will be applied prior to any deductions for co-payments or TPL, including Medicare payments

180 Day Time Limit for Claim Submittal

- As a result of the SMART Act claims received with dates of service on or after July 1, 2012 are subject to a filing deadline of 180 days from the date of service
- For details and a list of exceptions to the 180 day timely filing deadline please refer to the July 23, 2012 provider notice at:
<http://www.hfs.illinois.gov/assets/072312n.pdf>
- and the March 22, 2013 clarification notice at:
<http://www.hfs.illinois.gov/assets/032213n.pdf>
- *Timely filing applies to both initial and re-submitted claims*
- Claims submitted greater than 180 days but less than 365 days from the date of service will reject G55 ; Claims submitted greater than 365 days from the date of service will reject D05
- Medicare crossovers (Medicare payable claims) are subject to a filing deadline of two years from the date of service

Exceptions to the 180 Day Time Limit

Written requests for timely filing overrides for any of the exceptions in the following slides, and as stated in the July 23, 2012 provider notice, require a manual override and must be submitted with an original clean claim form and any attachments as indicated in the following slides to:

HFS – Bureau of Professional and Ancillary Services (BPAS)

Attn: Practitioner Billing Consultant

P.O. Box 19115

Springfield, IL 62794-9115

***Timely filing will be the only edit authorized for bypass. Should there be rejections due to billing errors unrelated to timely filing, those claims will not be allowed another time override.**

Exceptions to the 180 Day Time Limit

- Medicare denied claims – up to 2 years from the date of service. Attach to a paper claim form HFS 2360, HFS 1443, or HFS 2211: the EOMB showing HIPAA-compliant denial reason/remark codes and cover letter stating the reason for request for timely filing override.
- New provider enrollment or addition of an alternate payee - up to 180 days from the “as of” date for these changes on the HFS Provider Information Sheet. Attach to a paper claim: the provider information sheet applicable to the change and a cover letter stating the reason for request for timely filing override.
- Retroactive recipient eligibility – up to 180 days from the system update. Attach to a paper claim: a cover letter stating the reason for request for timely filing override.
- TPL – up to 180 days from final adjudication by the primary payer. Complete TPL fields on a paper claim and attach: a cover letter stating the reason for request and EOB from the primary payer.
- Primary TPL recoupment – up to 180 days from the date of the recoupment notification. Attach to a paper claim: a copy of the recoupment notification and cover letter stating the reason for request for timely filing override

Exceptions to 180 Day Time Limit (con't)

- Split bill – up to 180 days from the date on the HFS 2432 Split Billing Transmittal/Spenddown Form. Attach to a paper claim: the HFS 2432 and a cover letter stating the reason for request for timely filing override.
- Errors attributable to the Department – 180 days from the date the provider was notified of the error. Attach to a paper claim: a cover letter stating the reason for request for timely filing override.
- Replacement claims (one electronic transaction) – must be completed within 12 months from original paid voucher date to be considered timely
- Void & Re-bill (two separate transactions) – considered timely if the void transaction is completed within 12 months from original paid voucher date and the re-billed claim is received within 90 days of the void DCN. If manual override is required for the re-billed claim, attach to a paper claim: a cover letter stating the reason for request for timely filing override.
- Errors attributable to the Department or any of its claims processing intermediaries that result in an inability to receive, process or adjudicate a claim – the 180 day period shall not begin until the provider has been notified of the error via:
 - Date on the paper voucher/remittance advice
 - Fix date on the Claims Processing Systems Webpage at <http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx>

Co-Pays/Cost Sharing

- Co-pay amounts will *not* be reflected on the annual medical cards
- The provider notice dated March 29, 2013 and attached updated Appendix 12 at <http://www.hfs.illinois.gov/assets/032913n.pdf> provides the most up-to-date information about co-payment amounts and applicable eligibility categories.
- The Q & A document referenced in the February 14, 2014 provider notice regarding participant liability and co-payments is now available at the new Non-Institutional Providers Resources link at <http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx>
- When billing the Department *providers should not report the co-payment*, nor deduct it from their usual and customary charge, on the claim. The Department will automatically deduct the co-payment from the provider's reimbursement.
- The Department is in the process of issuing adjustments for some co-payments incorrectly taken. Please refer to the August 20, 2014 provider notice at <http://www.hfs.illinois.gov/assets/082014n.pdf> for details.

Co-Pays/Cost Sharing (con't)

Participants excluded from cost sharing include:

- Participants with Medicare as primary payer
- Pregnant women, including a 60-day postpartum period. *Either a primary diagnosis of pregnancy in the V22-V39 series or 640-677 series on the claim or current/updated EDD (estimated due date) on the MEDI system are required.*
- All Kids Assist (HFS-covered children under 19 years of age who are not All Kids Share or All Kids Premium)
- Residents of nursing homes, ICFs for the developmentally disabled, and supportive living facilities
- Hospice patients
- All non-institutionalized individuals whose care is subsidized by DCFS or Corrections
- Participants enrolled in HFS MCOs

Co-Pays/Cost Sharing (con't)

Services exempt from cost sharing include:

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

Co-Pays/Cost Sharing for IHW

Services and co-payment amounts for participants enrolled in the Illinois Health Women program, effective with dates of service on or after July 16, 2012 as a result of the SMART Act include:

- Family planning (birth control) medical services, including office visits, and contraceptive methods – no co-pay
- Family planning-*related* services, including office follow-up visits for abnormal pap findings, HPV vaccination, and infections - \$3.90 co-pay
- Contraceptive methods – no co-pay
- Other prescriptions: \$2.00 co-pay for generic prescriptions, \$3.90 for name-brand prescriptions

Co-pays/Cost Sharing and TPL

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

Fee-For-Service Billing by Hospitals

- Hospitals may submit fee-for-service charges for specific services performed in the hospital outpatient setting at the hospital's main campus or in a hospital-owned off-site clinic within 35 miles of the main hospital campus
- Evaluation and management services are not billable FFS by hospitals, with the exception of 99211 with modifier TH for the purpose of OB triage when there is no billable APL procedure
- Refer to Chapter 200, Topic 202.13 Allowable Fee-For-Service Charges by Hospitals for further information and billing guidelines

Fee-For-Service Billing by Hospitals (con't)

Services billable FFS by hospitals:

- Administration of chemotherapy agents for the treatment of cancer
- Administration and supply of the following injectable medications:
 - Chemotherapy agents for the treatment of cancer
 - Non-chemotherapy drugs administered for conditions associated with the chemotherapy and submitted with the cancer-related diagnosis
 - Baclofen
 - Lupron
 - RhoGAM
 - Tysabri
- **PLEASE NOTE: although previously billable, Synagis is no longer reimbursed FFS to hospitals effective April 1, 2014 per policy stated in the June 2, 2005 provider notice. A notice to clarify this policy is forthcoming.
- Reference (outside) laboratory services
- Outpatient laboratory and radiology services ordered by a physician
- Durable Medical Equipment and Supplies
- Speech and Occupational Therapy
- Telehealth
- E/M service 99211 with modifier TH for the purpose of OB triage *ONLY when there is no billable APL procedure*

Payment for Chemotherapy Services

- In addition to being billable in the outpatient setting by FFS hospitals, chemotherapy administration is billable by physicians and APNs in the office setting
- No payment is made for venous or arterial puncture performed for the purpose of administering chemotherapy
- In addition to the chemotherapy administration, the practitioner may submit charges for the *initial* office visit only. Follow-up visits are included in the chemotherapy administration fee.
- Except for the initial office visit, practitioners may bill for office visits on the same date of service as chemotherapy administration only when done for a separately identifiable condition and billed with modifier 25

Office Visits

- All E/M CPT codes require a face-to face-encounter with the physician/APN/PA. The only exception is 99211, which may be billed when a recipient comes to the office for a service, such as an injection, and the physician is not required to be present.
- When a therapeutic procedure is performed during an office visit, reimbursement will be made for whichever service the department prices higher, either the visit or the procedure, but not for both unless it is an initial office visit.
- Diagnostic services are paid separately from a visit based on medical necessity.
- A participant may be designated as a “new patient” only once in a lifetime by an individual practitioner, partner of the practitioner or collectively in a group regardless of the number of practitioners who may eventually see the participant.

EPSDT Codes

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

****Please note revisions to the Healthy Kids Handbook are pending and a new Healthy Kids handbook will be announced via provider notice and posted to the website soon****
- Developmental Screening
 - 96110
- Developmental Assessments
 - 96111
- Immunizations (Vaccine billing instructions are located in Chapter 200, Appendix A-8)
 - 90476-90749

EPSDT Codes (Con't)

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

- Hearing Screening
 - 92551

- Vision Screening
 - 99173

- Labs/X-rays

- Mental Health Risk Assessment
 - 99420

Additional information may be found in the Healthy Kids Handbook (HK-200) & Appendices at: <http://www.hfs.illinois.gov/handbooks/>

Adult Preventive Services

➤ Adult Preventive Visits

- 99385-99387 new patients
- 99395-99397 established patients

➤ Immunizations

- payable when medically necessary and administered according to CDC guidelines
- example: influenza or pneumococcal

➤ Screening for cancer

BMI Assessment & Obesity-Related Weight Management Follow-Up for Children & Adolescents

- Please refer to the January 24, 2014 provider notice at <http://www.hfs.illinois.gov/assets/012414n2.pdf> for details and billing instructions
- Providers are encouraged to follow recommended clinical guidelines for the evaluation & management of overweight and obesity according to the expert committee recommendations linked in the notice
- Primary care physicians and other providers are encouraged to routinely assess and document children's weight status at least one time per year for patients ages 2 through 20
- BMI assessment may be done during any sick or preventive visit. Claims for an episode where BMI is assessed must include the appropriate CPT and diagnosis codes as referenced in the notice
- Providers may bill for weight management visits for children with BMI >85th percentile as measured and documented according to the notice. Payable weight management visits may include a maximum of 3 visits within 6 months and may not be billed on the same day as a preventive medicine visit.

Prenatal/Perinatal Services

➤ Prenatal Services

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

➤ Perinatal Depression Risk Assessment

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

➤ Additional information is available at:

<http://www.hfs.illinois.gov/assets/112904pd.pdf>

Newborn Eligibility

- Any child born to a participant is automatically eligible for medical assistance for one (1) year as long as the mother remains eligible for assistance and the child lives with her
- The mother is not required to submit a formal application for the child to be added to her case
- Medical providers may request that a newborn be added to the Medical Assistance case by contacting the local DHS Family Community Resource Center. Local site locations can be found at: www.dhs.state.il.us
- Both DHS and HFS are aware of recent issues with newborn eligibility, including coverage that is not backdated to the infant's DOB and multiple RIN situations. Providers who experience these issues should contact the DHS E-RIN Help Desk at 800-843-0872.

Newborn Care

- *Normal* newborn care is considered the inpatient service provided to a newborn who does not develop complications prior to discharge from the hospital
- Charges for *normal* newborn care, when the child's name does not appear on the medical card, may be submitted as follows:
 - Patient Name – enter “Baby Girl” or “Baby Boy”
 - Date of Birth – enter the newborn's birth date
 - Recipient Identification Number – enter the mother's RIN
 - Date of Service – complete the service date box to show the date newborn care was provided
- Billing must be submitted with the child's name and recipient number when:
 - The newborn develops complications (i.e. jaundice)
 - The newborn is transferred to NICU
 - A newborn male is circumcised
 - Services are provided after discharge

Concurrent Care

- When a participant requires the specialized service(s) of an additional practitioner, either concurrently or intermittently during a period of hospitalization, reimbursement may be made for the services of both the attending and consulting practitioner(s)
- Each practitioner must identify the diagnosis he/she is personally treating
- Refer to Chapter A-200, Section A-220.82 Concurrent Care for information regarding documentation and billing guidelines

Critical Care

- When a participant receives critical care services in the inpatient, outpatient or ER setting, the practitioner is to bill using the appropriate critical care E/M CPT code
- Payment 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
- Refer to Chapter 200, Topic A-220.8 Critical Care Services for further information and billing guidelines

Hospital Care

➤ Observation

- Practitioners may charge for hospital observation care by using the appropriate CPT code in accordance with CPT guidelines
- If the participant 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 observation services.
- Payment will not be made for observation care for consecutive dates of service and only one observation CPT may be billed. The code for observation care “discharge” is not a covered service.

➤ Inpatient Care

- The admitting practitioner may charge for the initial hospital care of the participant only if not previously provided in the practitioner’s office or on an outpatient basis prior to scheduling the hospital admission
 - Only one attending/admitting practitioner will be paid for the initial hospital visit
 - After the day of admission, the attending practitioner may bill one subsequent hospital visit per day, although payment is not allowed for a visit by the same practitioner who performs/bills a diagnostic or therapeutic procedure on the same date of service
- **Refer to Chapter 200, Topics A-220.4 and A-220.5 for further information and billing guidelines**

Consultations

- A consultation is the service rendered by a practitioner at the request of another practitioner, with respect to the diagnosis and/or treatment of a particular illness or condition, with the consultant not assuming direct care of the participant
- The consultation claim must be submitted with the name and NPI of the referring practitioner in the appropriate fields
- A written report from the consulting practitioner to the requesting practitioner is to be included in both the consulting and referring practitioner's medical records
- Refer to Chapter 200, Topic A-220.6 Consultations for further information and billing guidelines

Anesthesia Services

- Anesthesia services may be provided by the anesthesiologist or the CRNA and should be reported according to the Anesthesia guidelines in the CPT book
- The anesthesiologist or CRNA may bill HFS for services when not paid by the hospital or other entity as an employee or independent contractor
- Anesthesia time must be reported in minutes
- Refer to Appendix A-7 for anesthesia pricing information
- When an office surgical procedure requires the administration of local anesthesia, no additional charge can be made for the anesthesia agent or administration, as both are considered part of the operative procedure
- Refer to Chapter 200, Topic 221 Anesthesia for further information and billing guidelines

Surgical Services

- Payment for a procedure identified on the Practitioner Fee Schedule as major includes postoperative office visits and customary wound dressings for a period of 30 days
- If the patient experiences a complication, such as an infection, that requires additional visits, submit the claim on paper with supporting documentation for a separately identifiable E/M service and use the modifier 25
- Charges for burn procedures (debridement, grafts, etc.) include postoperative visits, wound care and dressing changes for 7 days after the surgical procedure
- When submitting claims for multiple and/or complex procedures, attach the operative report to the claim form. Ensure that the operative report date is the service date indicated on the claim.

Surgical Services (con't)

- Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package
- Procedures considered incidental to, or a component of, the major procedure will not be paid separately
- When more than one operative session is necessary on the same day, operative reports must be submitted with the claim(s) identifying the separate operative times
- Use appropriate modifiers when identifying multiple/bilateral procedures – refer to the Practitioner Fee Schedule Key for instructions for billing multiples
- Use appropriate modifiers when the procedure(s) performed involved digits
- Refer to Chapter A-200, Section A-222 Surgery for further information and billing guidelines

Multiple Radiology Procedures

- Multiple radiology procedures on the same day involving areas of the body that are considered overlapping are either paid at a reduced rate or rejected as an x-ray procedure previously paid
- This applies to all services including x-rays, CT/CTAs and MRI/MRAs
- Separate payment will be made for an x-ray and CT of the same area of the body if medically necessary
- Separate payment will be made for CTs and MRIs of completely separate areas of the body
- Refer to Chapter 200, Topic A-224 Radiology Services for billing guidelines and examples of overlapping studies

Therapy Services

- A practitioner may charge only for an *initial* therapy treatment (prior to referral to a licensed therapist) provided in the practitioner's office by the practitioner or the practitioner's salaried staff under the practitioner's direct supervision
 - This may be billed in addition to the appropriate evaluation and management CPT code
 - Ongoing therapy services are only reimbursed to an enrolled individual therapist
 - Individual therapists and hospitals should refer to Chapter J-200, Handbook for Providers of Therapy Services at <http://www2.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf>
 - and the therapy fee schedule at http://www2.illinois.gov/hfs/SiteCollectionDocuments/therapy_feesched.pdf for information regarding therapy services
- *Please be aware any SMART Act or Senate Bill 741 changes supersede information in the handbook, which is undergoing revision***

IHW/Family Planning

- This program will end 12/31/14, as participants may be eligible for coverage under ACA adult provisions
- Current Covered Services can be viewed at:
<http://hfs.illinois.gov/html/120407ihw.html> OR
<http://www.illinoishealthywomen.com/>
- Bill the appropriate CPT code(s) for services provided
- Bill the FP modifier with the E/M CPT code – the E/M code billed includes the pelvic exam, breast exam and the obtaining of the Pap specimen.
- Bill the appropriate family planning diagnosis code from the V25 series when required.

Provider Fee Schedules

- The Practitioner Fee Schedule is updated quarterly and is posted at: <http://www.hfs.illinois.gov/feeschedule/>
- The most recent Practitioner Fee Schedule was posted to the website in May and is effective with dates of service beginning April 1, 2014
- The Practitioner Fee Schedule provides information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization. The fee schedule consists of a key, modifier listing, lab panel table with components and rates, and the listing of billable CPT and HCPCS codes.
- Additional fee schedules, such as those for optometry, chiropractic, podiatry, audiology, and therapy, are posted at: <http://www.hfs.illinois.gov/reimbursement/>

Third Party Liability

- Medicaid is nearly always the payer of last resort. All known TPL must be billed before claims may be submitted to HFS. Exceptions include services to women with a diagnosis of pregnancy and preventive services for children.
 - Antepartum care services are not required to bill a participant's private insurance carrier prior to billing the department, however practitioners must bill a participant's private insurance carrier prior to billing the department for deliveries
 - Please refer to topic A-223.41 **Prenatal Care** and A-223.44 **Delivery** of Chapter 200 of the Providers Handbook at:
<http://www2.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf>
 - Client-specific TPL appears on the MEDI eligibility detail screen
 - Medicare crossover claims must contain the amount paid by Medicare for each service
 - When a client is identified on the HFS system as having TPL, even if the client or TPL source states the TPL is not in effect, the claim must contain complete TPL information, including:
 - TPL resource code - TPL Resource Code Directory appears in Chapter 100 Appendix 9
 - TPL status codes – TPL status codes appear in Appendix 1 of most Chapter 200 Provider Handbooks
 - Payment amounts
 - TPL date - instructions appear in Appendix 1 of most Chapter 200 Provider Handbooks
- **for discrepancies between TPL reported by participants and that seen on MEDI please contact the TPL unit at 217-524-2490

HFS Paper Claim Forms

- HFS 2360 – Instructions in Chapter 200, Appendix A-1:
 - Physicians
 - APNs
- HFS 1443 – Instructions in Chapter 200, Appendix B-1:
 - Chiropractors
 - Podiatrists
 - Therapists (PT, OT and Speech)
 - Audiologists
 - Optometrists
 - SASS (Children's mental health)
- HFS 3797 – Instructions in Chapter 200, Appendix A-2:
 - All providers billing Medicare crossovers

**Please refer to instructions in the appendices for details regarding required, conditionally required, and optional fields

HIPAA 5010

- The HIPAA 5010 version of the 837P was fully implemented on May 1, 2012
- The Chapter 300 Companion Guide for 5010 may be viewed at: [http://www.hfs.illinois.gov/handbooks/chapter 300.html](http://www.hfs.illinois.gov/handbooks/chapter%20300.html)
- 5010 submissions will receive a 999 Functional Acknowledgement
- **Please note: A second 999 Functional Acknowledgment is possible as additional audit checks are completed. A second 999 always indicates rejection of the file(s). Please be aware of this possibility and verify that HFS has accepted all submitted files.**

Medical Electronic Data Interchange (MEDI)

- MEDI is available for:
 - Verifying client eligibility
 - Submitting claims
 - Submitting replacement claims (bill type '7')
 - Submitting voids (bill type '8')
 - Checking claim status
- Login and access requires a State of Illinois Digital Identity
- For new users:
 - Obtaining a State of Illinois Digital ID is a one-time process
 - Requires entry of Illinois-based information from Driver's License/State Identification Card
 - Registration must match the provider's information sheet
- There are two types of USER registration in the MEDI System:
 - Administrator (required - limit of 2)
 - Employees (no limit)

MEDI (con't)

- ANSI 835 (Electronic Remittance Advice) is in Production
- The 835 is available to the designated payee
- HFS error codes are not included on the 835. Codes given on the 835 are national reason and remark codes which can be found at: <http://www.wpc-edi.com/codes>.
- Providers should refer to the subsequent paper remittance advice for additional information regarding claim rejections

MEDI (con't)

- Once the Illinois Digital Identity registration is complete, login to: www.myhfs.illinois.gov

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

- For technical assistance with the following please contact 1-800-366-8768, option 1, option 3:
 - registration
 - digital certificate/password reset
 - administrator/biller authorization

Voids & Replacement Claims

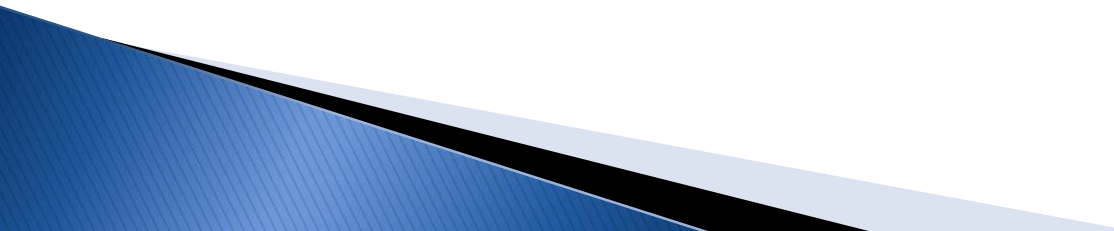
➤ Voids

- May be completed on paper by using the HFS 2292 NIPs Adjustment Form. Forms are free of charge and may be requested online using the Medical Forms Request webpage at: <http://www2.illinois.gov/hfs/MedicalProvider/Forms%20Request/Pages/default.aspx>. The instructions for completion of the HFS 2292 may be found in Appendix 6 of the Chapter 100 handbook at : <http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/Chapter100.aspx>
- May be completed electronically by using bill type '8' to void a single service line or entire claim

➤ Replacement Claims

- completed electronically by using bill type '7' to void a single service line or entire claim
- The instructions for electronic voids and replacement claims may be found in the Chapter 300 Companion Guide at <http://www2.illinois.gov/hfs/SiteCollectionDocuments/837p.pdf>
- Please Note: voids and replacement claims require the 17-digit DCN from the original, paid claim. Using the 12-digit DCN from the paper remit:
 - Add '201' to the beginning of that 12-digit number
 - Add **either** the 2-digit section number to void or replace a single service line, **or** '00' to void or replace an entire claim, to the end of that 12-digit number

Referring/Ordering Practitioner

- In the future, referring/ordering and prescribing practitioners will be required to be enrolled with Medicaid
 - A provider notice will be posted on the HFS website prior to implementation
- 

National Correct Coding Initiative (NCCI)

- Medicaid is required to enforce the NCCI edits that Medicare has used for several years
- HFS continues to review updates to these edits as they are published and implement payment policy changes accordingly

ICD - 10

- The Department of Health and Human Services announced final rule delaying the deadline for implementation of ICD-10 until October 1, 2015. This change was announced by HFS in the June 6, 2014 provider notice at <http://www.hfs.illinois.gov/assets/060614n.pdf>.
- Effective for dates of service on or after that date, HFS will no longer accept ICD-9 diagnosis codes on claims. ICD-9 diagnosis codes will only be accepted on claims with dates of service prior to October 1, 2015.

COMMON BILLING ERRORS

- A43 – service not covered – client has IHW coverage
- C03 – illogical quantity
- C17 – place of service illogical
- D01 – duplicate claim – previously paid
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 – client in MCO – Integrated care program
- R36 – client has Medicare – bill Medicare first
- X05 – Hospital visit disallowed
- X06 – surgical package previously paid
- H50 – payee not valid for provider
- M93 – missing payee/multiple payees
- H55 – rendering NPI missing/invalid
- G55 – submitted later than 180 days, but not more than one year, from date of service
- C97 – No payable service on claim (generally seen on encounter claims)
- T21 -- Client has Third Party Liability

Chap. 100 Handbook, Appendix 5 details HFS remittance advice error codes at:

<http://www.hfs.illinois.gov/assets/100app5.pdf>

Contact Numbers for Billing Questions or Prior Approval

Main Number : 877-782-5565

- Hospital or UB92 : option 1
- UB92 Transplants : option 2
- Physicians, Chiropractors, Podiatrists : option 3, option 1
- Audiologists & DME : option 3, option 2
- Transportation : option 3, option 3
- Optical : option 3, option 4
- LEA, Home Health, Therapies : option 3, option 5
- Prior Approval for DME : option 5, option 1
- Prior Approval for Home Health/Therapies : option 5, option 2

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

<http://www.hfs.illinois.gov>

- Laws and Rules:
<http://www.hfs.illinois.gov/lawsrules>
- Handbooks, including appendices:
<http://www.hfs.illinois.gov/handbooks/>
 - Chapter 100 – General Policy and Procedures
 - Chapter 200 – Physician Handbook
 - Chapter 300 – Handbook for Electronic Processing
- Provider Releases and E-Mail Notification for Releases: <http://www.hfs.illinois.gov/releases/>

Questions

