TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section
140.1 Incorporation By Reference
140.2 Medical Assistance Programs
140.3 Covered Services Under Medical Assistance Programs
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under General Assistance
140.6 Medical Services Not Covered
140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Incarcerated Persons

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section
140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Recovery of Money
140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.18 Effect of Termination or Revocation on Persons Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
140.20 Submittal of Claims
140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or

Part B and Are Eligible for Some Form of Medicaid Benefits
140.22 Magnetic Tape Billings (Repealed)
140.23 Payment of Claims
140.24 Payment Procedures
140.25 Overpayment or Underpayment of Claims
140.26 Payment to Factors Prohibited
140.27 Assignment of Vendor Payments
140.28 Record Requirements for Medical Providers
140.30 Audits
140.31 Emergency Services Audits
140.32 Prohibition on Participation, and Special Permission for Participation
140.33 Publication of List of Sanctioned Entities
140.35 False Reporting and Other Fraudulent Activities
140.40 Prior Approval for Medical Services or Items
140.41 Prior Approval in Cases of Emergency
140.42 Limitation on Prior Approval
140.43 Post Approval for Items or Services When Prior Approval Cannot Be Obtained
140.44 Withholding of Payments Due to Fraud or Misrepresentation
140.55 Recipient Eligibility Verification (REV) System
140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
140.72 Drug Manual (Recodified)
140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

Section
140.80 Hospital Provider Fund
140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund
140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
140.95 Hospital Services Trust Fund
140.96 General Requirements (Recodified)
140.97 Special Requirements (Recodified)
140.98 Covered Hospital Services (Recodified)
140.99 Hospital Services Not Covered (Recodified)
140.100 Limitation On Hospital Services (Recodified)
140.101 Transplants (Recodified)
140.102 Heart Transplants (Recodified)
140.103 Liver Transplants (Recodified)
140.104 Bone Marrow Transplants (Recodified)
140.110 Disproportionate Share Hospital Adjustments (Recodified)

140.116 Payment for Inpatient Services for GA (Recodified)
140.117 Hospital Outpatient and Clinic Services (Recodified)
140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
140.203 Limits on Length of Stay by Diagnosis (Recodified)
140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
140.350 Copayments (Recodified)
140.360 Payment Methodology (Recodified)
140.361 Non-Participating Hospitals (Recodified)
140.362 Pre July 1, 1989 Services (Recodified)
140.363 Post June 30, 1989 Services (Recodified)
140.364 Prepayment Review (Recodified)
140.365 Base Year Costs (Recodified)
140.366 Restructuring Adjustment (Recodified)
140.367 Inflation Adjustment (Recodified)
140.368 Volume Adjustment (Repealed)
140.369 Groupings (Recodified)
140.370 Rate Calculation (Recodified)
140.371 Payment (Recodified)
140.372 Review Procedure (Recodified)
140.373 Utilization (Repealed)
140.374 Alternatives (Recodified)
140.375 Exemptions (Recodified)
140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)
140.391 Definitions (Recodified)
140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)
140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.398 Hearings (Recodified)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section
140.400 Payment to Practitioners
140.402 Copayments for Noninstitutional Medical Services
140.403 Telehealth Services
140.405 SeniorCare Pharmaceutical Benefit (Repealed)
140.410 Physicians' Services
140.411 Covered Services By Physicians

140.412 Services Not Covered By Physicians
140.413 Limitation on Physician Services
140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers
140.416 Optometric Services and Materials
140.417 Limitations on Optometric Services
140.418 Department of Corrections Laboratory
140.420 Dental Services
140.421 Limitations on Dental Services
140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items – Dentists (Repealed)
140.425 Podiatry Services
140.426 Limitations on Podiatry Services
140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items – Podiatry (Repealed)
140.428 Chiropractic Services
140.429 Limitations on Chiropractic Services (Repealed)
140.430 Independent Clinical Laboratory Services
140.431 Services Not Covered by Independent Clinical Laboratories
140.432 Limitations on Independent Clinical Laboratory Services
140.433 Payment for Clinical Laboratory Services
140.434 Record Requirements for Independent Clinical Laboratories
140.435 Advanced Practice Nurse Services
140.436 Limitations on Advanced Practice Nurse Services
140.438 Diagnostic Imaging Services
140.440 Pharmacy Services
140.441 Pharmacy Services Not Covered
140.442 Prior Approval of Prescriptions
140.443 Filling of Prescriptions
140.444 Compounded Prescriptions
140.445 Legend Prescription Items (Not Compounded)
140.446 Over-the-Counter Items
140.447 Reimbursement
140.448 Returned Pharmacy Items
140.449 Payment of Pharmacy Items
140.450 Record Requirements for Pharmacies
140.451 Prospective Drug Review and Patient Counseling
140.452 Mental Health Services
140.453 Definitions
140.454 Types of Mental Health Services
140.455 Payment for Mental Health Services
140.456 Hearings
140.457 Therapy Services
140.458 Prior Approval for Therapy Services

140.459 Payment for Therapy Services
140.460 Clinic Services
140.461 Clinic Participation, Data and Certification Requirements
140.462 Covered Services in Clinics
140.463 Clinic Service Payment
140.464 Hospital-Based and Encounter Rate Clinic Payments
140.465 Speech and Hearing Clinics (Repealed)
140.466 Rural Health Clinics (Repealed)
140.467 Independent Clinics
140.469 Hospice
140.470 Eligible Home Health Providers
140.471 Description of Home Health Services
140.472 Types of Home Health Services
140.473 Prior Approval for Home Health Services
140.474 Payment for Home Health Services
140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
140.476 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices for Which Payment Will Not Be Made
140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices
140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
140.479 Limitations, Medical Supplies
140.480 Equipment Rental Limitations
140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids
140.482 Family Planning Services
140.483 Limitations on Family Planning Services
140.484 Payment for Family Planning Services
140.485 Healthy Kids Program
140.486 Illinois Healthy Women
140.487 Healthy Kids Program Timeliness Standards
140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures
140.490 Medical Transportation
140.491 Limitations on Medical Transportation
140.492 Payment for Medical Transportation
140.493 Payment for Helicopter Transportation
140.494 Record Requirements for Medical Transportation Services
140.495 Psychological Services
140.496 Payment for Psychological Services
140.497 Hearing Aids
140.498 Fingerprint-Based Criminal Background Checks

SUBPART E: GROUP CARE

Section

140.500 Long Term Care Services
140.502 Cessation of Payment at Federal Direction
140.503 Cessation of Payment for Improper Level of Care
140.504 Cessation of Payment Because of Termination of Facility
140.505 Informal Hearing Process for Denial of Payment for New ICF/MR
140.506 Provider Voluntary Withdrawal
140.507 Continuation of Provider Agreement
140.510 Determination of Need for Group Care
140.511 Long Term Care Services Covered By Department Payment
140.512 Utilization Control
140.513 Notification of Change in Resident Status
140.514 Certifications and Recertifications of Care (Repealed)
140.515 Management of Recipient Funds – Personal Allowance Funds
140.516 Recipient Management of Funds
140.517 Correspondent Management of Funds
140.518 Facility Management of Funds
140.519 Use or Accumulation of Funds
140.520 Management of Recipient Funds – Local Office Responsibility
140.521 Room and Board Accounts
140.522 Reconciliation of Recipient Funds
140.523 Bed Reserves
140.524 Cessation of Payment Due to Loss of License
140.525 Quality Incentive Program (QUIP) Payment Levels
140.526 County Contribution to Medicaid Reimbursement (Repealed)
140.527 Quality Incentive Survey (Repealed)
140.528 Payment of Quality Incentive (Repealed)
140.529 Reviews (Repealed)
140.530 Basis of Payment for Long Term Care Services
140.531 General Service Costs
140.532 Health Care Costs
140.533 General Administration Costs
140.534 Ownership Costs
140.535 Costs for Interest, Taxes and Rent
140.536 Organization and Pre-Operating Costs
140.537 Payments to Related Organizations
140.538 Special Costs
140.539 Reimbursement for Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide Training and Nursing Assistant Competency Evaluation
140.540 Costs Associated With Nursing Home Care Reform Act and Implementing Regulations
140.541 Salaries Paid to Owners or Related Parties

140.542 Cost Reports – Filing Requirements
140.543 Time Standards for Filing Cost Reports
140.544 Access to Cost Reports (Repealed)
140.545 Penalty for Failure to File Cost Reports
140.550 Update of Operating Costs
140.551 General Service Costs Updates
140.552 Nursing and Program Costs
140.553 General Administrative Costs Updates
140.554 Component Inflation Index (Repealed)
140.555 Minimum Wage
140.560 Components of the Base Rate Determination
140.561 Support Costs Components
140.562 Nursing Costs
140.563 Capital Costs
140.565 Kosher Kitchen Reimbursement
140.566 Out-of-State Placement
140.567 Level II Incentive Payments (Repealed)
140.568 Duration of Incentive Payments (Repealed)
140.569 Clients With Exceptional Care Needs
140.570 Capital Rate Component Determination
140.571 Capital Rate Calculation
140.572 Total Capital Rate
140.573 Other Capital Provisions
140.574 Capital Rates for Rented Facilities
140.575 Newly Constructed Facilities (Repealed)
140.576 Renovations (Repealed)
140.577 Capital Costs for Rented Facilities (Renumbered)
140.578 Property Taxes
140.579 Specialized Living Centers
140.580 Mandated Capital Improvements (Repealed)
140.581 Qualifying as Mandated Capital Improvement (Repealed)
140.582 Cost Adjustments
140.583 Campus Facilities
140.584 Illinois Municipal Retirement Fund (IMRF)
140.590 Audit and Record Requirements
140.642 Screening Assessment for Nursing Facility and Alternative Residential Settings and Services
140.643 In-Home Care Program
140.645 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21 (Repealed)
140.646 Reimbursement for Developmental Training (DT) Services for Individuals With Developmental Disabilities Who Reside in Long Term Care (ICF and SNF) and Residential (ICF/MR) Facilities

140.647 Description of Developmental Training (DT) Services
140.648 Determination of the Amount of Reimbursement for Developmental Training (DT) Programs
140.649 Effective Dates of Reimbursement for Developmental Training (DT) Programs
140.650 Certification of Developmental Training (DT) Programs
140.651 Decertification of Day Programs
140.652 Terms of Assurances and Contracts
140.680 Effective Date Of Payment Rate
140.700 Discharge of Long Term Care Residents
140.830 Appeals of Rate Determinations
140.835 Determination of Cap on Payments for Long Term Care (Repealed)

SUBPART F: FEDERAL CLAIMING FOR STATE AND LOCAL GOVERNMENTAL ENTITIES

Section
140.850 Reimbursement of Administrative Expenditures
140.855 Administrative Claim Review and Reconsideration Procedure
140.860 County Owned or Operated Nursing Facilities
140.865 Sponsor Qualifications (Repealed)
140.870 Sponsor Responsibilities (Repealed)
140.875 Department Responsibilities (Repealed)
140.880 Provider Qualifications (Repealed)
140.885 Provider Responsibilities (Repealed)
140.890 Payment Methodology (Repealed)
140.895 Contract Monitoring (Repealed)
140.896 Reimbursement For Program Costs (Active Treatment) For Clients in Long Term Care Facilities For the Developmentally Disabled (Recodified)
140.900 Reimbursement For Nursing Costs For Geriatric Residents in Group Care Facilities (Recodified)
140.901 Functional Areas of Needs (Recodified)
140.902 Service Needs (Recodified)
140.903 Definitions (Recodified)
140.904 Times and Staff Levels (Repealed)
140.905 Statewide Rates (Repealed)
140.906 Reconsiderations (Recodified)
140.907 Midnight Census Report (Recodified)
140.908 Times and Staff Levels (Recodified)
140.909 Statewide Rates (Recodified)
140.910 Referrals (Recodified)
140.911 Basic Rehabilitation Aide Training Program (Recodified)
140.912 Interim Nursing Rates (Recodified)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section

140.920 General Description
140.922 Covered Services
140.924 Maternal and Child Health Provider Participation Requirements
140.926 Client Eligibility (Repealed)
140.928 Client Enrollment and Program Components (Repealed)
140.930 Reimbursement
140.932 Payment Authorization for Referrals (Repealed)

SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

Section

140.940 Illinois Competitive Access and Reimbursement Equity (ICARE) Program (Recodified)
140.942 Definition of Terms (Recodified)
140.944 Notification of Negotiations (Recodified)
140.946 Hospital Participation in ICARE Program Negotiations (Recodified)
140.948 Negotiation Procedures (Recodified)
140.950 Factors Considered in Awarding ICARE Contracts (Recodified)
140.952 Closing an ICARE Area (Recodified)
140.954 Administrative Review (Recodified)
140.956 Payments to Contracting Hospitals (Recodified)
140.958 Admitting and Clinical Privileges (Recodified)
140.960 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)
140.962 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)
140.964 Contract Monitoring (Recodified)
140.966 Transfer of Recipients (Recodified)
140.968 Validity of Contracts (Recodified)
140.970 Termination of ICARE Contracts (Recodified)
140.972 Hospital Services Procurement Advisory Board (Recodified)
140.980 Elimination Of Aid To The Medically Indigent (AMI) Program (Emergency Expired)
140.982 Elimination Of Hospital Services For Persons Age Eighteen (18) And Older And Persons Married And Living With Spouse, Regardless Of Age (Emergency Expired)

SUBPART I: PRIMARY CARE CASE MANAGEMENT PROGRAM

Section
140.990 Primary Care Case Management Program
140.991 Primary Care Provider Participation Requirements
140.992 Populations Eligible to Participate in the Primary Care Case Management Program
140.993 Care Management Fees
140.994 Panel Size and Affiliated Providers
140.995 Mandatory Enrollment
140.996 Access to Health Care Services
140.997 Payment for Services

SUBPART J: ALTERNATE PAYEE PARTICIPATION

Section
140.1001 Registration Conditions for Alternate Payees
140.1002 Participation Requirements for Alternate Payees
140.1003 Recovery of Money for Alternate Payees
140.1004 Conditional Registration for Alternate Payees
140.1005 Revocation of an Alternate Payee

SUBPART K: MANDATORY MCO ENROLLMENT

140.1010 Mandatory Enrollment in MCOs

140.TABLE A Medichek Recommended Screening Procedures (Repealed)
140.TABLE B Geographic Areas
140.TABLE C Capital Cost Areas
140.TABLE D Schedule of Dental Procedures
140.TABLE E Time Limits for Processing of Prior Approval Requests
140.TABLE F Podiatry Service Schedule
140.TABLE G Travel Distance Standards
140.TABLE H Areas of Major Life Activity
140.TABLE I Staff Time and Allocation for Training Programs (Recodified)
140.TABLE J HSA Grouping (Repealed)
140.TABLE K Services Qualifying for 10% Add-On (Repealed)
140.TABLE L Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule

adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986;

amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg.7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989;

amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186,

effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency

amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill.

Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the maximum 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill.

Reg. 18323, effective November 12, 2008; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; peremptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011; amended at 35 Ill. Reg. 7962, effective May 1, 2011; amended at 35 Ill. Reg. 10000, effective June 15, 2011; amended at 35 Ill. Reg. 12909, effective July 25, 2011.

SUBPART A: GENERAL PROVISIONS

Section 140.1 Incorporation by Reference

Any rules or regulations of an agency of the United States or of a nationally recognized organization or association that are incorporated by reference in this Part are incorporated as of the date specified, and do not include any later amendments or editions.

(Source: Added at 9 Ill. Reg. 2697, effective February 22, 1985)

Section 140.2 Medical Assistance Programs

a) Under the Medical Assistance Programs, the Department pays participating providers for necessary medical services, specified in Section 140.3 through 140.7 for:

1) persons eligible for financial assistance under the Aid to the Aged, Blind or Disabled-State Supplemental Payment (AABD-SSP) and Temporary Assistance to Needy Families (TANF) programs (Medicaid-MAG);

2) persons who would be eligible for financial assistance but who have resources in excess of the Department's eligibility standards and who have incurred medical expenses greater than the difference between their income and the Department's standards (Medicaid-MANG);

3) persons receiving financial assistance under the General Assistance (GA) program, either State Transitional Assistance or State Family and Children Assistance (GA-Medical);

4) individuals under age 18 who do not qualify for TANF/TANF-MANG and infants under age one year (see Section 140.7);

5) pregnant women who would not be eligible for TANF/TANF-MANG if the child were born and who do not qualify as mandatory categorically needy (see Section 140.9);

6) persons who are eligible for Title IV-E adoption assistance/foster care assistance from another State and who are living in Illinois;

7) noncitizens who have an emergency medical condition (see 89 Ill. Adm. Code 120.310); however, payment is not included for care and services related to an organ transplant procedure;

8) persons eligible for medical assistance under the Aid to the Aged, Blind or Disabled (AABD) program who reside in specified Supportive Living Facilities (SLFs), as described at 89 Ill. Adm. Code 146, Subpart B; and

9) persons eligible for FamilyCare as described in 89 Ill. Adm. Code 120.32 and 120.34 and 89 Ill. Adm. Code 118.600, Subpart F.

b) "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment.

c) The Department may impose prior approval requirements, as specified by rule, to determine whether the medical care is necessary and eligible for payment from the Department in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.

d) When recipients are entitled to Medicare benefits, the Department shall assume responsibility for their deductible and coinsurance obligations, unless the recipients have income and/or resources available to meet these needs. The total payment to a provider from both Medicare and the Department shall not exceed either the amount that Medicare determines to be a reasonable charge or the Department standard for the services provided, whichever is applicable.

e) The Department shall pay for services and items not allowed by Medicare only if they are provided in accordance with Department policy for recipients not entitled to Medicare benefits.

f) The Department may contract with qualified practitioners, hospitals and all other dispensers of medical services for the provision and reimbursement of any and all medical care or services as specified in the contract on a prepaid capitation basis (i.e., payment of a fixed amount per enrollee made in advance of the service); volume purchase basis (i.e., purchase of a volume of goods or services for a price specified in the contract); ambulatory visit basis (i.e., one comprehensive payment for each visit regardless of the services provided during that visit) or per discharge basis (i.e., one comprehensive payment per discharge regardless of the services provided during the stay). Such contracts shall be based either on formally solicited competitive bid proposals or individually negotiated rates with providers willing to enter into special contractual arrangements with the State.

g) The Department may require that recipients of medical assistance under any of the Department's programs exercise their freedom of choice by choosing to receive medical care under the traditional fee for service system or through a prepaid capitation plan or under one of the other alternative contractual arrangements described in subsection (f) of this Section. The categories of recipients who may choose or be assigned to an alternative plan will be specified in the contract. Recipients required to make such a choice will be notified in writing by the Department. If a recipient does not choose to exercise his/her freedom of choice, the Department may assign that recipient to a prepaid plan. Under such a plan, recipients would obtain certain medical services or supplies from a single source or limited source. The Department will notify recipients in writing if they are assigned to a prepaid plan. Recipients enrolled in or assigned to a prepaid plan will receive written notification advising them of the services which they will receive from the plan. Covered services not provided by the plan will be reimbursed by the Department on a fee for service basis. Recipients will receive a

medical eligibility card, which will apply to such services.

h) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization (HMO) whereby the recipient who chooses to receive medical care through an HMO must stay in the HMO for a certain period of time, not to exceed six months (the enrollment period). Upon written notice, the recipient may choose to disenroll from such an HMO at any time within the first month of each enrollment period. The Department will send the recipient a notice at least 30 days prior to the end of the enrollment period, which gives the recipient a specified period of time in which to inform the Department if the recipient does not wish to re-enroll in the HMO for a new enrollment period. The recipient may then disenroll at the end of the enrollment period only if the recipient responds to the notice and indicates in writing a choice to disenroll. Failure to respond to the notice will result in automatic re-enrollment for a new enrollment period. Recipients shall also be allowed to disenroll at any time for cause.

i) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization whereby the recipient who chooses to receive medical care through an HMO may choose to disenroll at any time, upon written notice.

j) The Department shall pay for services under the Maternal and Child Health Program, a primary health care program for pregnant women and children (see Subpart G).

k) Services covered for persons who are confined or detained as described in 89 Ill. Adm. Code 120.318(b) shall be limited as described in Section 140.10.

(Source: Amended at 35 Ill. Reg. 394, effective December 27, 2010)

Section 140.3 Covered Services Under Medical Assistance Programs

a) As described in this Section, medical services shall be covered for:

1) recipients of financial assistance under the AABD (Aid to the Aged, Blind or Disabled), TANF (Temporary Assistance to Needy Families), or Refugee/Entrant/Repatriate programs;

2) recipients of medical assistance only under the AABD program (AABD-MANG);

3) recipients of medical assistance only under the TANF program (TANF-MANG);

4) individuals under age 18 not eligible for TANF (see Section 140.7), pregnant women who would be eligible if the child were born and pregnant women and children under age eight who do not qualify as mandatory categorically needy (see Section 140.9);

5) disabled persons under age 21 who may qualify for Medicaid or in-home care under the Illinois Home and Community-Based Services Waiver for Medically Fragile Technology Dependent Children;

6) recipients eligible under the State Transitional Assistance Program who are determined by the Department to be disabled; and

7) Individuals 19 years of age or older eligible under the KidCare Parent

Coverage Waiver as described at 89 Ill. Adm. Code 120.32 except for:

A) Services provided only through a waiver approved under section 1915(c) of the Social Security Act; and

B) Termination of pregnancy.

b) The following medical services shall be covered for recipients under age 21 who are included under subsection (a):

1) Inpatient hospital services;

2) Hospital outpatient and clinic services;

3) Hospital emergency room visits. The visit must be for the alleviation of

severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment;

4) Encounter rate clinic visits;

5) Physician services;

6) Pharmacy services;

7) Home health agency visits;

8) Laboratory and x-ray services;

9) Group care services;

10) Family planning services and supplies;

11) Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;

12) Transportation to secure medical services;

13) EPSDT services pursuant to Section 140.485;

14) Dental services;

15) Chiropractic services;

16) Podiatric services;

17) Optical services and supplies;

18) Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396;

19) Hospice services;

20) Nursing care pursuant to Section 140.472;

21) Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting pursuant to 89 Ill. Adm. Code 146, Subpart D; and

22) Telehealth services pursuant to Section 140.403.

c) The following medical services shall be covered for recipients age 21 or over who are included under subsection (a):

1) Inpatient hospital services;

2) Hospital outpatient and clinic services;

3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment;

4) Encounter rate clinic visits;

5) Physician services;

6) Pharmacy services;

7) Home health agency visits;

8) Laboratory and x-ray services;

9) Group care services;

10) Family planning services and supplies;

11) Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;

12) Transportation to secure medical services;

13) Subacute alcoholism and substance abuse services pursuant to Sections 140.390 through 140.396;

14) Hospice services;

15) Dental services;

16) Chiropractic services;

17) Podiatric services;

18) Optical services and supplies; and

19) Telehealth services pursuant to Section 140.403.

(Source: Amended at 34 Ill. Reg. 903, effective January 29, 2010)

Section 140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)

(Source: Repealed at 9 Ill. Reg. 14684, effective September 13, 1985)

Section 140.5 Covered Medical Services Under General Assistance

a) The following medical services shall be covered for recipients of financial assistance under General Assistance for both the State Transitional Assistance Program and the State Family and Children Assistance Program:

1) Encounter rate clinic visits;

2) Physician services;

3) Vital pharmacy services (items necessary for life maintenance or to avoid life threatening situations);

4) Vital medical supplies and equipment;

5) Group care services, subject to prior approval;

6) Family planning services;

7) Laboratory and x-ray services;

8) Transportation to secure medical services;

9) Prostheses, orthoses (only when essential for employment or expediting hospital discharge);

10) Home health agency visits (only on a prior approval basis when the medical condition is documented by the physician as terminal);

11) Hospice services;

12) Dental services;

13) Chiropractic services;

14) Podiatric services; and

15) Optical services and supplies.

b) The following medical services shall be covered for recipients of financial assistance under General Assistance only for the State Family and Children Assistance Program, not the State Transitional Assistance Program, in addition to the services covered under subsection (a) above:

1) Inpatient hospital services. (Physical rehabilitation services and psychiatric services are not covered for General Assistance recipients age 18 or over);

2) Hospital outpatient and clinic services for surgical procedures, renal dialysis or cancer therapy; and

3) Hospital emergency room visits. The visit must be for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment.

(Source: Amended at 23 Ill. Reg. 12697, effective October 1, 1999)

Section 140.6 Medical Services Not Covered

The following services are not covered under the Department's medical assistance programs:

a) Services available without charge;

b) Services prohibited by State or Federal law;

c) Experimental procedures;

d) Research oriented procedures;

e) Medical examinations required for entrance into educational or vocational programs;

f) Autopsy examinations;

g) Preventive services, except those provided through the Medicheck program for children through age 20, and required school examinations;

h) Routine examinations;

i) Artificial insemination;

j) Abortion, except in accordance with Rule 4.03;

k) Medical or surgical procedures performed for cosmetic purposes;

l) Medical or surgical transsexual treatment;

m) Diagnostic and/or therapeutic procedures related to primary infertility/sterility;

n) Acupuncture;

o) Subsequent treatment for venereal disease, when such services are available through State and/or local health agencies;

p) Medical care provided by mail or telephone;

q) Unkept appointments;

r) Non-medically necessary items and services provided for the convenience of recipients and/or their families;

s) Preparation of routine records, forms and reports;

t) Visits with persons other than a recipient, such as family members or group care facility staff.

(Source: Amended and codified at 7 Ill. Reg. 7965, effective July l, 1983)

Section 140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight

a) Individuals Under Age Eighteen (18)

1) Medical assistance shall be provided to individuals under the age of eighteen who do not qualify for AFDC under the definition of dependent child as defined in 89 Ill. Adm. Code 101.20 and 112.60 through 112.64. However, such individuals must meet the eligibility requirements and other provisions of 89 Ill. Adm. Code ll2.l0, ll2.20, 112. Subparts C and D, ll2.303, ll2.304 and ll2.307 through ll2.309.

2) If non-exempt countable income is equal to or less than the appropriate MANG (AFDC) standard the individual is eligible for payment of his/her allowable medical care costs.

3) Persons whose income exceeds the appropriate MANG (AFDC) standard are eligible for medical assistance each month incurred or paid medical care costs equals the amount of excess non-exempt income over the standard. When income exceeds the MANG (AFDC) standard, eligibility begins on the day in the month incurred or paid medical care costs equals excess monthly income. Eligibility ends on the last day of the same month.

b) Children Under Age Eight (8) Medical assistance shall be provided to children under age six (6) who do not qualify as mandatory categorically needy (Social Security Act (42 U.S.C. 1902(a)(10)(A)(i) and 1905(n)) and meet the eligibility requirements of 89 Ill. Adm. Code 120.11, 120.31, 120.64.

(Source: Amended at 15 Ill. Reg. 11176, effective August 1, 1991)

Section 140.8 Medical Assistance For Qualified Severely Impaired Individuals

Medical assistance shall be provided under the AABD program to a qualified severely impaired individual whose Supplemental Security Income (SSI) payment status is based on Section 1619 of the Social Security Act (the Act) (42 U.S.C. 1382h)) if he/she was eligible for Medicaid in the month prior to first becoming eligible under Section 1619 of the Act (see 89 Ill. Adm. Code 113: Subparts B and C, and 89 Ill. Adm. Code 120.10 and 120.60). A qualified severely impaired individual is any person under age 65 who received either SSI, State Supplemental Payment or special Section 1619(a) of the Act benefits and was eligible for Medicaid and who the Social Security Administration determines meets all of the following criteria:

a) is blind or disabled under Title XVI of the Act (see 42 U.S.C. 1382c);

b) meets all SSI requirements except for earned income;

c) would be seriously inhibited by the lack of Medicaid coverage from continuing to work or obtaining employment; and

d) has earnings insufficient to provide a reasonable equivalent of Medicaid, SSI and Title XX (42 U.S.C. 1397 et seq.) attendant care benefits that would be available if he/she did not work.

(Source: Added at 12 Ill. Reg. 916, effective January 1, 1988)

Section 140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy

a) Pregnant Women Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born

1) Medical assistance will be provided to applicants of any age who are pregnant and meet the asset standards of the AFDC medical assistance program and who would not be eligible for AFDC if the child were already born because:

A) the father is not absent, and

B) neither parent is incapacitated and the principal wage earner does not meet the Department's definition of unemployment (see 89 Ill. Adm. Code 112.64).

2) Medical Assistance for up to sixty (60) days following the last day of pregnancy

A) Medical assistance shall be provided for the woman and newborn child for 60 days following the last day of the pregnancy. The sixty (60) day medical coverage continues through the last day of the calendar month in which the sixty (60) day period ends.

B) In order for a pregnant woman to qualify for the extended sixty (60) day medical coverage, an AFDC MANG application must have been filed prior to the date the pregnancy ended.

b) Pregnant Women Who Do Not Qualify As Mandatory Categorically Needy

1) Medical assistance shall be provided to women of any age who do not qualify as mandatory categorically needy (Sections 1902(a)(10)(A)(i) and 1905(n) of the Social Security Act) and meet the eligibility requirements of 89 Ill. Adm. Code 120.11, 120.31 and 120.64).

2) Medical Assistance shall be provided for the woman and newborn child(ren) for up to sixty (60) days following the last day of the pregnancy. The sixth (60) day medical coverage continues through the last day of the calendar month in which the sixty (60) day period ends.

(Source: Amended at 12 Ill. Reg. 19734, effective November 15, 1988)

Section 140.10 Medical Assistance Provided to Persons Confined or Detained by the Criminal Justice System

a) The Department shall pay for certain medical services provided to the following groups of individuals who are confined or detained in county jails or other detention facilities in Illinois, that are not operated by the State, and who are eligible for, and enrolled in, medical assistance administered under Article V of the Illinois Public Aid Code [305 ILCS 5]:

1) Individuals who, at the time of confinement or detention, were already enrolled for medical assistance.

2) Individuals who, subsequent to their confinement or detention, were determined eligible and enrolled for medical assistance.

b) Reimbursement of hospital inpatient services. The Department will directly reimburse hospitals pursuant to 89 Ill. Adm. Code 147, 148 and 152 for inpatient hospital services provided to those covered under subsections (a)(1) and (2) of this Section.

c) Reimbursement of other services:

1) With respect to medical services provided to individuals described in subsection (a)(1), the Department shall reimburse the county or arresting authority (a unit of local government other than a county that employs peace officers who make the arrest) for a portion of the cost of medical services, other than hospital inpatient services, that are:

A) Provided to the individual during his or her period of confinement or detention;

B) Covered for the class of persons described in Section 5-2 of the Public Aid Code under which the individual is enrolled;

C) Provided by medical providers that are enrolled with the Department to participate in the medical assistance program; and

D) Provided pursuant to a county or arresting authority ordinance or resolution providing for reimbursement for the cost of medical services at the reimbursement levels established by the Department for medical assistance under Article V of the Public Aid Code.

2) The county or arresting authority requesting reimbursement from the

Department must submit the following documentation in a form and format specified by the Department:

A) Information necessary to adjudicate a claim for each service provided, including, but not limited to:

i) the name, birth date, Social Security number and recipient identification number of the individual receiving the medical service;

ii) the name, address and provider number of the health care provider that provided the service;

iii) the service provided, including applicable diagnosis, procedure and national drug codes; and

iv) the provider charges and the amount paid by the county or arresting authority for the services.

B) The date of confinement and, if applicable, the date of release or transfer to another criminal justice authority.

C) Verification that the services claimed for reimbursement correspond to the services rendered.

D) A copy of the ordinance or resolution providing for reimbursement for the cost of medical services at the reimbursement levels established by the Department for medical assistance pursuant to Article V of the Public Aid Code.

3) The Department will adjudicate each claim applying its reimbursement rates and, to the extent that the cost of care for the individual exceeds $500 accumulated over the individual's period of confinement, will reimburse the county or arresting authority the amount in excess of $500.

(Source: Amended at 35 Ill. Reg. 394, effective December 27, 2010)

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.11 Enrollment Conditions for Medical Providers

a) In order to enroll for participation, providers shall:

1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors;

2) Be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX participation;

3) Be certified for Title XIX when federal or State rules and regulations so require;

4) Provide enrollment information to the Department in the prescribed format, and notify the Department, in writing, immediately whenever there is a change in any such information which the provider has previously submitted;

5) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to public aid recipients; and

6) Have a written provider agreement on file with the Department.

b) Approval of a corporate entity such as a pharmacy, laboratory, durable medical equipment and supplies provider, medical transportation provider, nursing home or renal satellite facility, as a participant in the Medical Assistance Program, applies only to the entity's existing ownership, corporate structure and location; therefore, participation approval is not transferable.

c) Except for children's hospitals described at 89 Ill. Adm. Code 149.50(c)(3), hospitals providing inpatient care that are certified under a single Medicare number shall be enrolled as an individual entity in the Medical Assistance Program. A children's hospital must be separately enrolled from the general care hospital with which it is affiliated.

d) Upon notification from the Illinois Department of Public Health of a change of ownership, the Department shall notify the prospective buyer of its obligation

under Section 140.12(l) to assume liability for repayment to the Department for overpayments made to the current owner or operator. Such notification shall inform the prospective buyer of all outstanding known liabilities due to the Department by the facility and of any known pending Department actions against the facility that may result in further liability. For long term care providers, when there is a change of ownership of a facility or a facility is leased to a new operator, the provider agreement shall be automatically assigned to the new owner or lessee. Such assigned agreement shall be subject to all conditions under which it was originally issued, including, but not limited to, any existing plans of correction, all requirements of participation as set forth in Section 140.12 or additional requirements imposed by the Department.

e) For purposes of administrative efficiency, the Department may periodically require classes of providers to re-enroll in the Medical Assistance Program. Under such re-enrollments, the Department shall request classes of providers to submit updated enrollment information. Failure of a provider to submit such information within the requested time frames will result in the dis-enrollment of the provider from the Program. Such dis-enrollment shall have no effect on the future eligibility of the provider to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program. A dis-enrolled provider may reapply to the Program and all such re-applications must meet the requirements for enrollment.

f) For purposes of this Section, a vendor whose investor ownership has changed by 50 percent or more from the date the vendor was initially approved for enrollment in the Medical Assistance Program shall be required to submit a new application for enrollment in the Medical Assistance Program. All such applications must meet the requirements for enrollment.

g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a non-emergency transportation vendor, as defined in Section 140.13, shall be conditional for 180 days, during which time the Department may terminate the vendor's eligibility to participate in the Medical Assistance Program without cause. Upon termination of a non-emergency transportation vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:

1) individuals with management responsibility;

2) all owners or partners in a partnership;

3) all officers of a corporation or individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership

in a corporation; or

4) an owner of a sole proprietorship.

h) Termination of eligibility, as described in subsection (g) of this Section, and resulting barrments are not subject to the Department's hearing process.

(Source: Amended at 32 Ill. Reg. 7727, effective May 5, 2008)

Section 140.12 Participation Requirements for Medical Providers

The provider shall agree to:

a) Verify eligibility of recipients prior to providing each service;

b) Allow recipients the choice of accepting or rejecting medical or surgical care or treatment;

c) Provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations pertaining to nondiscrimination and equal employment opportunity including but not limited to:

1) Full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin;

2) Full compliance with Section 504 of the Rehabilitation Act of 1973 and 45 CFR 84, which prohibit discrimination on the basis of handicap; and

3) Without discrimination on the basis of religious belief, political affiliation, sex, age or disability;

d) Comply with the requirements of applicable federal and State laws and not engage in practices prohibited by such laws;

e) Provide, and upon demand present documentation of, education of employees, contractors and agents regarding the federal False Claims Act (31 USC 3729-3733) that complies with all requirements of 42 USC 1396a(a)(68). Providers subject to this requirement include a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, that receives or makes payments totaling at least $5 million annually;

f) Hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding recipients;

g) Furnish to the Department, in the form and manner requested by it, any information it requests regarding payments for providing goods or services, or in connection with the rendering of goods or services or supplies to recipients by the provider, his agent, employer or employee;

h) Make charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges and in the same quality

and mode of delivery as are provided to the general public;

i) Accept as payment in full the amounts established by the Department.

1) If a provider accepts an individual eligible for medical assistance from the Department as a Medicaid recipient, such provider shall not bill, demand or otherwise seek reimbursement from that individual or from a financially responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department. For purposes of this subsection, "accepts" shall be deemed to include:

A) an affirmative representation to an individual that payment for services will be sought from the Department;

B) an individual presents the provider with his or her medical card and the provider does not indicate that other payment arrangements will be necessary; or

C) billing the Department for the covered medical service provided an eligible individual.

2) If an eligible individual is entitled to medical assistance with respect to a service for which a third party is liable for payment, the provider furnishing the service may not seek to collect from the individual payment for that service if the total liability of the third party for that service is at least equal to the amount payable for that service by the Department.

j) Accept assignment of Medicare benefits for public aid recipients eligible for Medicare, when payment for services to such persons is sought from the Department;

k) Complete an MCH (Maternal and Child Health) Primary Care Provider Agreement in order to participate in the Maternal and Child Health Program (see Section 140.924(a)(1)(D)); and

l) In the case of long term care providers, assume liability for repayment to the Department of any overpayment made to a facility regardless of whether the overpayment was incurred by a current owner or operator or by a previous owner or operator. Liability of current and previous providers to the Department shall be joint and several. Recoveries by the Department under this Section may be made pursuant to Sections 140.15 and 140.25. A current or previous owner or lessee may request from the Department a list of all known outstanding liabilities due the Department by the facility and of any known pending Department actions

against a facility that may result in further liability. For purposes of this Section, "overpayment" shall include, but not be limited to:

1) Amounts established by final administrative decisions pursuant to 89 Ill. Adm. Code 104;

2) Overpayments resulting from advance C-13 payments made pursuant to Section 140.71;

3) Liabilities resulting from nonpayment or delinquent payment of assessments pursuant to Sections 140.82, 140.84 and 140.94; and

4) Amounts identified during past, pending or future audits that pertain to audit periods prior to a change in ownership and are conducted pursuant to Sections 140.30 and 140.590. Liability of current owners or operators for amounts identified during such audits shall be as follows:

A) For past audits (audits completed before changes in ownership), liability shall be the amount established by final administrative decision.

B) For pending audits (audits initiated, but not completed prior to the change in ownership), liability shall be limited to the lesser of the amounts established by final administrative decision or two months of service revenue. Two months of service revenue is defined as the most recent two months of Medicaid patient days multiplied by the total Medicaid rate in effect on the date the new owner or operator is enrolled in the Program as a provider by the Department. The Medicaid rate in effect on the date of enrollment shall be used even if that rate is subsequently changed.

C) For future audits (audits initiated after the change in ownership but pertaining to an audit period prior to a change in ownership), liability shall be limited as described in subsection (k)(4)(B) of this Section.

(Source: Amended at 31 Ill. Reg. 8485, effective May 30, 2007)

Section 140.13 Definitions

"Alternate Payee". For purposes of this Part, "Alternate Payee" shall mean an entity that is registered as an alternate payee in the Medical Assistance Program. An individual practitioner may designate payments due the practitioner be made to an alternate payee.

"Department Policy". For purposes of this Part, "Department policy" shall mean the written requirements of the Department set forth in the Medical Assistance Program Handbooks, and the Department's written manuals, bulletins and releases. It shall also include any additional policy statements transmitted in writing to a vendor.

"Entity". For purposes of this Part, "entity" means any person, firm, corporation, partnership, association, agency, institution, or other legal organization.

"Investor". For purposes of this Part, "investor" shall mean any entity that owns (directly or indirectly) five percent or more of the shares of stock or other evidences of ownership of a vendor, or holds (directly or indirectly) five percent or more of the debt of a vendor, or owns and holds (directly or indirectly) three percent or more of the combined debt and equity of a vendor.

"Management Responsibility". For purposes of this Part, a person with management responsibility includes a person vested with discretion or judgment who either alone or in conjunction with others, conducts, administers or oversees either the general concerns of the vendor or a portion of the vendor's concerns. A person with management responsibility shall specifically include the pharmacist in a pharmacy, the medical director of a laboratory, the administrator of a hospital or nursing home, the dispatcher in a transportation vendor, dispatchers and all individuals in charge of day to day operations of a non-emergency transportation vendor, the person or persons responsible for preparation and submittal of billings for services to the Department, and the manager of a group practice, clinic or shared health facility.

"Non-Emergency Transportation Vendor". For purposes of this Part, non-emergency transportation vendor shall mean any transportation provider identified in Section 140.490(a) other than those identified in Section 140.490(a)(1) and (a)(6).

"Technical or Other Advisor". For purposes of this Part, "technical or other advisor" shall mean any entity that provides any form of advice to a vendor regarding the vendor's business or participation in the Medical Assistance Program in return for compensation, directly or indirectly, in any form.

"Vendor". For purposes of this Part, "vendor" or "provider" shall mean a person, firm, corporation, association, agency, institution, or other legal entity that provides goods or services to a recipient or recipients, and is enrolled to participate in the Medical Assistance Program pursuant to 89 Ill. Adm. Code 140.11 and 140.12.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.14 Denial of Application to Participate in the Medical Assistance Program

a) The Department may deny an application to participate in the Medical Assistance Program if the vendor has engaged in activities which constitute grounds for termination or suspension under Section 140.16. If the activities were engaged in prior to December 1, 1977, they may be used as the basis for denial of an application only if the vendor had actual or constructive knowledge of the requirements which applied to his conduct or activities.

b) In addition to the above basis, the Department may deny an application submitted by a vendor that has been previously terminated, barred or denied participation if:

1) such vendor cannot reasonably be expected to meet the written requirements of the Department including those set forth in the Medical Assistance Program Handbooks and the Department's manuals, bulletins and releases; or

2) the Department determines, after reviewing the activities which served as the basis for the earlier termination or barring, that the application should not be approved. Factors to be considered by the Department in making this determination shall include:

A) length of time the vendor has not participated in the Medical Assistance Program;

B) magnitude and severity of the activities which led to the binding administrative decision which served as the basis for the vendor's termination, barring or denied participation;

C) mitigating circumstances presented by the vendor;

D) whether the deficiencies which served as the basis for the vendor to be terminated, barred or denied participation are corrected;

E) whether the vendor demonstrates a fitness to participate in the Medical Assistance Program; and

F) the extent to which any legally enforceable debts owed to the Department by the applicant or an entity in which the applicant or his nominee held a substantial ownership interest have been paid.

3) These factors must be established by submission of documentary evidence in support of the application.

c) The Department may deny an application of a previously terminated or barred applicant if the applicant, without special permission from the Department, has already become a vendor, an entity with management responsibility for a vendor, an incorporator, officer or member of the board of directors of a vendor, an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship vendor, a partner in a partnership vendor, a technical or other advisor to a vendor, or an investor in a vendor.

d) The Department shall deny an application to participate in the Medical Assistance Program if the vendor does not have a necessary license, certificate or authorization.

(Source: Amended at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.15 Recovery of Money

a) The Department may recover money improperly or erroneously paid, or overpayments (see subsection (b) of this Section for exception to recovery of money), either by setoff (deducting from Department obligations to the vendor or the designated alternate payee), deductions from future billings or by requiring direct repayment.

b) If a practitioner designates an alternate payee, the practitioner and the alternate payee shall be jointly and severally liable to the Department for payments made to the alternate payee. Recoveries by the Department may be made against either party or both, at the Department's option.

c) The Department shall not recoup from any long term care provider any amounts subsequently determined to be owed by a client due to an error in the initial determination of medical eligibility.

d) The Department shall recover interest on the amount of the overpayment at the rate of five percent per annum if it is established through an administrative hearing that the overpayment resulted from the vendor or the designated alternate payee willfully making, or causing to be made, a false statement or misrepresentation of a material fact in connection with billings and payments under the medical assistance program. For purposes of this Section, "willfully" means making a statement or representation with actual knowledge that it was false, or making a statement or representation with knowledge of facts or information that would cause a reasonable person to be aware that the statement or representation was false when made.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program

a) The Department may terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, or terminate or not renew a vendor's provider agreement, when it determines that, at any time:

1) The vendor is not complying with the Department's policy or rules, or with the terms and conditions prescribed by the Department in any vendor agreement developed as a result of negotiations with the vendor category, or with the covenants contained in certifications bearing the vendor's signature on claims submitted to the Department by the vendor, or with restrictions on participation imposed pursuant to Section 140.32(f);

2) The vendor is not properly licensed or qualified, or the vendor's professional license, certificate or other authorization has not been renewed or has been revoked, suspended or otherwise terminated as determined by the appropriate licensing, certifying or authorizing agency;

3) The vendor violates records requirements.

A) The vendor has failed to keep or make available for inspection, audit or copying (including photocopying), after receiving a written request from the Department:

i) records required to be maintained by the Department or necessary to fully disclose the extent of the services or supplies provided; or

ii) records required to be maintained by the Department regarding payments claimed for providing services.

B) This subsection (a)(3) does not require vendors to make available medical records of patients for whom services are not reimbursed under the Illinois Public Aid Code;

4) The vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services, or has failed to furnish all information required by the Department in connection with the rendering of services or supplies to recipients of public assistance by the vendor or his or her agent, employer or employee;

5) The vendor has knowingly made, or caused to be made, any false

statement or representation of a material fact in connection with the administration of the Medical Assistance Program. For purposes of this subsection (a)(5), statements or representations made "knowingly" shall include statements or representations made with actual knowledge that they were false as well as those statements made when the individual making the statement had knowledge of such facts or information as would cause one to be aware that the statements or representations were false when made;

6) The vendor has submitted claims for services or supplies that were not rendered or delivered by that vendor;

7) The vendor has furnished goods or services to a recipient that, when based upon competent medical judgment and evaluation, are determined to be:

A) in excess of the recipient's needs,

B) harmful to the recipient (for the purpose of this subsection (a)(7)(B), "harmful" goods or services caused actual harm to a recipient or placed a recipient at risk of harm, or of adverse side effects, that outweighed the medical benefits sought to be provided), or

C) of grossly inferior quality;

8) The vendor knew or should have known that a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an investor in the vendor, a technical or other advisor of the vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor was previously terminated or barred from participation in the Medical Assistance Program;

9) The vendor engaged in practices prohibited by Federal or State law or regulation.

A) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor, either:

i) has engaged in practices prohibited by applicable Federal or State law or regulation; or

ii) was a person with management responsibility for a vendor at the time that the vendor engaged in practices prohibited by applicable Federal or State law or regulation; or

iii) was an officer, or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a vendor at the time the vendor engaged in practices prohibited by applicable Federal or State law or regulation; or

iv) was an owner of a sole proprietorship or partner of a partnership that was a vendor at the time the vendor engaged in practices prohibited by applicable Federal or State law or regulation;

B) For purposes of this subsection (a)(9), "applicable Federal or State law or regulation" shall include licensing or certification standards contained in State or Federal law or regulations related to the Medical Assistance Program, any other licensing standards as they relate to the vendor's practice or business or any Federal or State laws or regulations related to the Medical Assistance Program;

C) For purposes of this subsection (a)(9), conviction or a plea of guilty to activities violative of applicable Federal or State law or regulation shall be conclusive proof that those activities were engaged in;

10) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor has been convicted in this or any other State, or in any Federal Court, of any felony not related to the Medical Assistance Program, if the felony constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;

11) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or partner in a partnership that is a

vendor has been convicted in this or any other state, or in any Federal court, of murder or a Class X felony under the Illinois Criminal Code of 1961;

12) The direct or indirect ownership of the vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual who is terminated or barred from participating as a vendor to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage.

b) The Department may suspend a vendor's eligibility to participate in the Medical Assistance Program if the vendor is not in compliance with State income tax requirements, child support payments in accordance with Article X of the Public Aid Code, or educational loans guaranteed by the Illinois Student Assistance Commission. The vendor may prevent suspension of eligibility by payment of past-due amounts in full or by entering into payment arrangements acceptable to the appropriate State agency.

(Source: Amended at 33 Ill. Reg. 11938, effective August 17, 2009)

Section 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program

In actions based on Section 140.16 in which the Notice states an intent to terminate, the final administrative decision may result in suspension for a specific time, which shall not exceed one year from the time of the final administrative decision, rather than termination, when the Department determines that:

a) the seriousness and extent of the violations do not warrant termination; and

b) the vendor had no prior history of violations of the Medical Assistance Program; and

c) the lesser sanction of suspension will be sufficient to remedy the problem created by the vendor's violations.

(Source: Amended at 16 Ill. Reg. 17302, effective November 2, 1992)

Section 140.18 Effect of Termination or Revocation on Persons Associated with Vendor

a) Upon termination of a vendor of goods or services from participation in the Medical Assistance Program, a person with management responsibility for such vendor during the time of any conduct that served as the basis for that vendor's termination is barred from participation in the Medical Assistance Program.

b) Upon termination of a corporate vendor, the officers and persons owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in the vendor during the time of any conduct that served as the basis for that vendor's termination are barred from participation in the Medical Assistance Program.

c) Upon termination of a sole proprietorship or partnership, the owner or partners during the time of any conduct that served as the basis for that vendor's termination are barred from participation in the Medical Assistance Program.

d) Upon revocation of an alternate payee pursuant to Section 140.1005, the owners, officers, and individuals with management responsibility for the alternate payee during the time of any conduct that served as the basis for that alternate payee's revocation may be prohibited from participation as an owner, an officer, or an individual with management responsibility for an alternate payee in the Illinois Medical Assistance Program.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring

a) A vendor that has been terminated from the Medical Assistance Program may not apply to participate for at least one year after the date of the final administrative decision terminating eligibility, except that, if a vendor has been terminated based on a conviction of a violation of Article VIIIA of the Public Aid Code [305 ILCS 5/Art. VIIIA] or a conviction of a felony based on fraud or a willful misrepresentation related to subsection (a)(1), (2), (3) or (4) of this Section, the vendor shall be barred from participation for five years or for the length of the vendor's sentence for that conviction, whichever is longer.

1) The Medical Assistance Program under Article V of the Public Aid Code [305 ILCS 5/Art. V];

2) A medical assistance program in another state that is the kind provided under Article V of the Public Aid Code;

3) The Medicare program under Title XVIII of the Social Security Act; or

4) The provision of health care services.

b) After one year, a vendor who has been terminated for any reason, other than for the reasons in subsections (a)(1) through (4) of this Section, may apply for reinstatement to the Medical Assistance Program. If a vendor's application for reinstatement is denied by the Department, he or she shall be barred from again applying for reinstatement for one year after the date of the final administrative decision denying his or her application for reinstatement.

c) At the end of a period of suspension, a vendor that has been suspended from the Medical Assistance Program shall be reinstated upon completion of the necessary enrollment forms and execution of a new vendor agreement unless it is determined that such vendor has not corrected the deficiencies upon which the suspension was based. If the deficiencies have not been corrected, the vendor shall, after notice and hearing, be terminated. The notice in any termination action based on this Section shall notify the vendor of the deficiencies not corrected.

d) An individual barred pursuant to Section 140.18 can apply to participate in the Medical Assistance Program. If an individual's application is denied by the Department or if he or she is denied special permission under Section 140.32, he or she shall be barred from again applying for one year after the date of the final administrative decision denying his or her application or special permission.

e) If a vendor has been terminated and reinstated to the Medical Assistance Program and the vendor is terminated a second or subsequent time from the Medical Assistance Program, the vendor shall be barred from participation for at least two years, except that, if a vendor has been terminated a second time based on a conviction of a violation of Article VIIIA of the Public Aid Code [305 ILCS 5/Art. VIIIA] or a conviction of a felony based on fraud or a willful misrepresentation related to subsection (a)(1), (2), (3) or (4) of this Section, the vendor shall be barred from participation for life.

f) At the end of two years, a vendor who has been terminated for any reason, other than for the reasons in subsections (a)(1) through (4) of this Section, may apply for reinstatement to the Medical Assistance Program. If a vendor's application for reinstatement is denied by the Department, he or she shall be barred from again applying for reinstatement for two years after the date of the final administrative decision denying his or her application for reinstatement.

(Source: Amended at 28 Ill. Reg. 7081, effective May 3, 2004)

Section 140.20 Submittal of Claims

a) When claims for payment are submitted to the Department, providers shall:

1) Use Department designated billing forms or electronic format for submittal of charges, and

2) Certify that:

A) They have personally rendered the services and provided the items for which charges are being made,

B) Payment has not been received, or that only partial payment has been received,

C) The charge made for each item constitutes the complete charge,

D) They have not, and will not, accept additional payment for any item from any person or persons, and

E) They will not make additional charges to, nor accept additional payment from, any persons if the charges they present are reduced by the Department to conform to Department standards.

b) Statement of Certification

1) All billing statements shall contain a certification statement that must remain unaltered, and must be legibly signed and dated in ink by the provider, his or her designated alternate payee, or his or her authorized representative. A rubber stamp or facsimile signature is not acceptable.

2) An "authorized representative" may only be a trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. Such representative must be specifically designated and must sign the provider's name and his or her own initials on each certification statement.

3) An alternate payee must be specifically designated by the provider and must sign the provider's name and alternate payee's authorized representative's initials on each certification statement.

c) To be eligible for payment consideration, a provider's vendor-payment claim or bill, either as an initial or resubmitted claim following prior rejection, must be

received by the Department, or its fiscal intermediary, no later than 12 months after the date on which medical goods or services were provided, with the following exception. The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than 24 months after the date on which medical goods or services were provided.

d) Claims that are not submitted and received in compliance with the foregoing requirements will not be eligible for payment under the Department's Medical Assistance Program, and the State shall have no liability for payment of the claim.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits

a) In order to be qualified to receive reimbursement for services provided to QMB (Qualified Medicare Beneficiary) eligible medical assistance recipients, QMB eligible only recipients (see 89 Ill. Adm. Code 120.72), or individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits, providers must be enrolled in the Medical Assistance Program. Providers must also accept assignment of Medicare benefits for QMB eligible medical assistance recipients and individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits, when payment for services to such persons is sought from the Department.

b) For Medicaid covered services, the Department will reimburse qualified providers who render services to QMB eligible medical assistance recipients, QMB eligible only recipients and individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefits in accordance with Department standards for the service(s) provided, with the following exception: for drugs and medical supplies provided by a pharmacy or Durable Medical Equipment (DME) provider, and reimbursed by Medicare, the Department's liability for deductible and coinsurance amounts shall be at the full Medicare rate. For individuals enrolled in the Senior Care Program, the provisions in this subsection (b) will apply to services provided on or after October 16, 2002.

c) For services approved by Medicare but not covered by Medicaid, the maximum allowable rate payable to qualified providers who render services to QMB eligible medical assistance recipients and recipients who are QMB eligible only is 80 percent of the full Medicare rate when determining the Department's liability for deductible and coinsurance amounts.

d) Licensed and Medicare certified nursing facilities that enroll for the sole purpose of receiving payment for services to QMB eligible only residents of the facility, then disenroll, are not subject to the provisions found in Section 140.506 governing voluntary withdrawal from the Medical Assistance Program.

(Source: Amended at 27 Ill. Reg. 4364, effective February 24, 2003)

Section 140.22 Magnetic Tape Billings (Repealed)

(Source: Repealed at 25 Ill. Reg. 3897, effective March 1, 2001)

Section 140.23 Payment Of Claims

a) The Department shall pay only for those services and supplies that:

1) Meet the U.S. Department of Health, Education and Welfare's definition of medical service, (42 U.S.C. 1396d),

2) Can be paid by vendor payment, and

3) Are specified in the individual rules governing particular types of medical services provided.

b) Except as provided in Paragraph (d), the Department shall make payment only after services have been rendered.

c) Payment shall be made only to a provider who

1) Participates in the Medical Assistance Program, and

2) Except as provided in Paragraph (d), is the actual provider of service.

d) The Department may contract with qualified practitioners, hospitals and all other dispensers of medical services for the provision and reimbursement as specified in the contract of any and all medical care or services on a prepaid capitation, volume purchase, ambulatory visit or per discharge basis. Such contracts shall be based either on formally solicited competitive bid proposals or individually negotiated rates with providers willing to enter into special contractual arrangements with the State. Payments shall be made in advance of services under prepaid capitation arrangements. The Department shall not pay a provider for services provided to a recipient enrolled in a HMO or other plan as specified above when the service is one which the HMO or plan has contracted to provide.

(Source: Amended at 8 Ill. Reg. 6785, effective April 27, 1984)

Section 140.24 Payment Procedures

a) Payment of valid claims will be made by a State warrant (check) issued through the Office of the State Comptroller.

b) All providers of medical services must designate a payee when enrolling in the Department's Medical Assistance Program.

1) Providers enrolled as business entities are limited to one payee. A business entity is defined as any firm, corporation, partnership, agency, institution or other legal organization organized for the purpose of providing medically related professional services. A provider enrolled as a business entity may designate the corporate or partnership name as the payee. The mailing address for the payee must be the provider's service address, the designated address of the provider's corporate or partnership office, or a designated address that will accept and forward the remittance advice to the business entity.

2) Providers enrolled as individual practitioners are allowed to have more than one payee. An individual practitioner is defined as an individual person licensed by an authorized State agency to provide medical services. Payment may be mailed to an individual practitioner at one of the following addresses that will accept and forward the remittance advice to the individual practitioner:

A) The provider's service address; or

B) The provider's residence; or

C) The provider's designated address; or

D) The address of the provider's designated alternate payee pursuant to subsection (d) of this Section; or

E) The address of the entity specified according to an arrangement under Section 140.27(c) or (d).

c) A long term care facility and its corporate or partnership owner may request the facility's warrant be sent directly to the business office address of the corporate or partnership owner. After approval is given, the warrant will be issued in the name of the facility or corporate name doing business under the facility name, but sent to the business office address of the corporate or partnership owner rather than the facility.

d) Individual practitioners may request the Department to designate an alternate payee. The Department may permit such a request if the Department determines that such designation is consistent with the provision of medical services to eligible recipients. The alternate payee must be registered as an alternate payee pursuant to Subpart J and:

1) The individual practitioner has a contractual/salary arrangement, as a condition of employment with a hospital or professional school. A professional school is defined as a college or university offering a degree to qualify individuals for licensure to perform medical services; or

2) The individual practitioner has a contractual/salary arrangement with or is employed by a practitioner owned group practice. The practitioner owned group practice must be owned by three or more full-time licensed individual practitioners who are eligible to participate in the Medical Assistance Program; or

3) The individual practitioner is a partner in a partnership and has a partnership arrangement that requires fees to be turned over to the partnership. The partnership must be solely-owned by two or more practitioners who are eligible to participate in the Medical Assistance Program; or

4) The individual practitioner has a contractual/salary arrangement or is employed by a governmental entity that requires, as a condition of employment, that the fees be turned over to the governmental entity; or

5) The individual practitioner has a contractual/salary arrangement or is employed by a community mental health agency that is certified by the Department of Human Services under 59 Ill. Adm. Code 132. The community mental health agency must be enrolled as a provider in the Medical Assistance Program; or

6) The individual practitioner has a contractual/salary arrangement or is employed by a Federally Qualified Health Center, Rural Health Center or Encounter Rate Clinic that is enrolled as a provider in the Medical Assistance Program; or

7) The individual practitioner has a contractual/salary arrangement or is employed by a hospital affiliate, as defined by the Hospital Licensing Act [210 ILCS 85]; or

8) The individual practitioner is employed by a corporation registered with the Illinois Secretary of State's Office to do business in the State of Illinois and whose shares of ownership are publicly traded in a recognized stock exchange within the United States of America; or

9) The individual practitioner "employer" requires an employee, as a condition of employment, to turn over his or her fees to the employer. The employer must be eligible to participate in the Medical Assistance Program and, except as provided below, must be licensed in the same profession as the practitioners in his or her employ who have designated the employer as the alternate payee. The employer may only qualify as a payee for a total of four individual practitioners, including the employer. Practitioners may designate an employer who is a physician licensed under the Medical Practice Act of 1987 [225 ILCS 60] if the practitioner is an advanced practice nurse licensed under the Nurse Practice Act [225 ILCS 65].

e) The Department will not permit the designation of a payee or alternate payee that appoints, employs, or contracts with any person as an owner, officer, director, or individual with management or advisory responsibility who is terminated, suspended, or barred or has voluntarily withdrawn as a result of a settlement agreement, from any state or federal healthcare program.

f) If a practitioner designates an alternate payee, the practitioner and the alternate payee shall be jointly and severally liable to the Department for payments made to the alternate payee.

(Source: Amended at 32 Ill. Reg. 17133, effective October 15, 2008)

Section 140.25 Overpayment or Underpayment of Claims

a) When the Department, the provider, or the designated alternate payee has determined that an overpayment has been made, the provider or the alternate payee shall reimburse the Department for the overpayment. The Department shall recover overpayments made to or on behalf of a provider that result from improper billing practices. Such recovery may occur by setoff, crediting against future billings or requiring direct repayment to the Department.

b) When a provider believes it has received an underpayment for services, it may request Department review. The request must be received by the Department within 12 months after the date payment was authorized. If the review reveals an underpayment was made, the Department shall pay the additional amount due. If the review reveals an overpayment was made, the provider, or the designated alternate payee, shall refund the amount of the overpayment.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.26 Payment to Factors Prohibited

a) Payment for any care or service furnished to an individual by a provider will not be made to or through a factor, either directly or by virtue of a power of attorney given by the provider to the factor. In addition, transfers by providers to a factor of any claims for reimbursement or receivables under the Medical Assistance Program, either by assignment, sale or otherwise is expressly prohibited. This prohibition shall include, but not be limited to, the following:

1) Transfer of such claims or receivables to a nonrelated entity, i.e., an organization in which the provider is neither an officer nor an owner, which has given the provider an unsecured loan,

2) Transfer of accounts for such claims or receiveables, or

3) The use of such claims or receivables by a provider as collateral for a loan, except as allowed under Section 140.27 ("Assignment of Vendor Payments").

b) For purposes of these Rules, "factor" shall mean an organization, i.e., collection agency or service bureau which, or an individual who, advances money to a provider for his accounts receivable which the provider has assigned or sold, or otherwise transferred, including transfer through the use of power of attorney, to this organization or individual. The organization or individual receives an added fee receivable in return for the advanced money.

(Source: Amended at 8 Ill. Reg. 22097, effective October 24, 1984)

Section 140.27 Assignment of Vendor Payments

a) Except as provided in this Section, vendor payments and the right to receive such payments are absolutely inalienable by assignment, sale, attachment, garnishment or otherwise.

b) A medical vendor may use his or her right to receive vendor payments as collateral for loans from banks, credit unions, and savings and loan associations chartered under or trust companies issued certificates of authority under Chapter 205 of the Illinois Compiled Statutes, provided that such arrangements:

1) shall not require the Department to issue the payment directly to any person or entity other than the vendor; and

2) shall not constitute any activities prohibited by the provisions of 42 U.S.C.A. 1396(a)(32) (1983) and Section 140.26 ("Payment to Factors Prohibited").

c) A medical vendor or other vendor or service provider may assign, reassign, sell, pledge or grant a security interest in any such financial aid, vendor payment or money payments of grants he or she has a right to receive to the Illinois Health Facilities Authority in connection with any financing program undertaken by that Authority, or to the Illinois Development Finance Authority in connection with any financing program undertaken by that Authority. Each Authority may utilize an agent or trustee accepting, accomplishing, effectuating or realizing upon any such assignment, reassignment, sale, pledge or grant on such Authority's behalf; and such arrangements may provide that the Department shall issue the payment directly to the Illinois Health Facilities Authority, Illinois Development Finance Authority or to any such agent or trustee.

d) A medical vendor that is a governmental entity or is exempt from income reporting under Section 1.6041-3(c) of the federal income tax regulations [26 CFR 1.6041-3(c)] and that provides Healthy Kids Program services under Section 140.485(d) may assign its interest in payment from the Department to a local school district with which the provider has an arrangement to provide such services. Under such assignment, with Department approval, payment will be made directly to the school district.

(Source: Amended at 19 Ill. Reg. 13019, effective September 5, 1995)

Section 140.28 Record Requirements for Medical Providers

a) Providers shall maintain in the regular course of business the following:

1) Any and all business records, that may indicate financial arrangements between the provider and other providers in the program or other entities, or that are necessary to determine compliance with federal and State requirements, including but not limited to:

A) business ledgers of all transactions,

B) records of all payments received, including cash,

C) records of all payments made, including cash,

D) corporate papers, including stock record books and minute books,

E) records of all arrangements and payments related in any way to the leasing of real estate or personal property, including any equipment,

F) records of all accounts receivable and payable; and

2) Any and all professional records that relate to the quality of care given by the provider or that document the care for which payment is claimed, including but not limited to:

A) medical records for applicants and recipients of public assistance. This rule does not require a provider to keep or make available medical records for persons who are not applicants or recipients and for whom no claim to the Department for payment is made.

B) other professional records required to be maintained by applicable federal or State law or regulations.

b) The business and professional records required to be maintained shall be kept in accordance with accepted business and accounting practice and shall be legible. Such records must be retained for a period of not less than 3 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period the records must be retained until the audit is completed and every exception resolved. This provision is not to be construed as a statute of limitations. However, the Department will not deny, suspend or terminate a provider pursuant to Sections

140.14 through 140.19 solely because the provider has failed to keep records for more than 3 years.

c) All records required to be maintained shall be available for inspection, audit and copying (including photocopying) by authorized Department personnel during normal business hours. Department personnel shall make all attempts to examine such records without interfering with the professional activities of the provider.

d) The provider's business and professional records for at least 12 previous calendar months shall be maintained and available for inspection by authorized Department personnel on the premises of the provider. Department personnel shall make requests in writing to inspect records more than 12 months old at least 2 days in advance of the date they must be produced.

e) The provider is responsible to furnish records to the Department. If records are maintained by a designated alternate payee or another entity, the provider remains responsible for obtaining those records and furnishing them to the Department.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.30 Audits

a) All services for which charges are made to the Department are subject to audit. During a review audit, the provider shall furnish to the Department or to its authorized representative, pertinent information regarding claims for payment. If records are maintained by a designated alternate payee, it is the provider's responsibility to obtain the records and furnish them to the Department. Should an audit reveal that incorrect payments were made, or that the provider's records do not support the payments that were made, or should the provider or designated alternate payee fail to furnish records to support payments that were made, the provider or designated alternate payee shall make restitution.

b) The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under such a procedure, the Department selects a statistically valid sample of the cases for which the provider or designated alternate payee received payment for the audit period in question and audits the provider's records for those cases. All incorrect payments determined by an audit of the cases in the sample are then totaled and extrapolated to the entire universe of cases for which the provider or designated alternate payee has been paid during the audit period. The provider or designated alternate payee shall be required to pay the Department the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing pursuant to 89 Ill. Adm. Code 104.210.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.31 Emergency Services Audits

a) All emergency services for which charges are made to the Department and are provided to a recipient who does not require admission as an inpatient are subject to audit.

b) An emergency services audit shall be limited to a review of records related to services rendered within three years of the date the hospital is notified that the audit will be initiated. The Department shall notify the hospital of an audit at least four calendar weeks before the audit occurs, unless the hospital and the Department agree to schedule the audit at an earlier date. The hospital's business and professional records for at least 12 previous calendar months shall be maintained and available for inspection by authorized Department personnel on the premises of the hospital. Department personnel shall make requests in writing to inspect records more than 12 months old at least two business days in advance of the date they must be produced. These records required to be maintained shall be kept in accordance with accepted business and accounting practice and shall be legible. Such records must be retained for a period of not less than three years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period the records must be retained until the audit is completed and every exception resolved by settlement or by the Director's final decision.

c) All records required to be maintained shall be available for inspection by authorized Department personnel during normal business hours. Department personnel shall make all attempts to examine such records without interfering with the professional activities of the hospital. The hospital shall make legible copies of those records requested by the Department upon completion of its inspection, and tender said copied records to the Department within two weeks after such request is made unless this time is extended by mutual consent. Additionally, if the hospital locates records that were unavailable during the audit, that data shall be submitted to the Department within 30 days after completion of the audit conducted on the hospital's premises, and that data shall be utilized in generating the audit findings. The determination that an emergency medical condition exists shall be based solely upon the review of the legible information contained in those medical records supplied by the hospital during the audit.

d) Authorized Department personnel shall meet with the chief executive officer of the hospital, or a person designated by the chief executive officer, upon arrival at the hospital to conduct the audit and at the conclusion of the audit. The purpose of the pre-audit meeting shall be to inform the hospital of the scope of the audit. The purpose of the post-audit meeting shall be to provide an opportunity for the

auditors to discuss their preliminary findings with the chief executive officer, or a person designated by the chief executive officer. More detailed audit findings shall be provided in writing to the hospital within 120 days of the date on which the audit conducted on the hospital premises was completed.

e) The final determination of whether an emergency room visit was for the alleviation of severe pain or for the immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death if there is not immediate treatment shall be based upon the symptoms and condition of the recipient at the time the recipient is initially examined by the hospital's emergency department physician and not upon the final determination of the recipient's actual medical condition (see Sections 140.3 and 140.5 of this Part).

f) Where the purpose of the audit is to determine the appropriateness of the emergency services provided, any final determination that would result in a denial of or reduction in payment to the hospital shall be based on the opinion of a physician licensed to practice medicine in all of its branches who is board certified in emergency medicine or by the appropriate health care professionals under the supervision of the physician.

g) The Department or its designated review agent in cases where the Department seeks to recover an extrapolated amount, shall use statistically valid sampling techniques when conducting audits as provided by Section 140.30 of this Part.

h) This Section shall not apply to any audits initiated prior to July 1, 1992.

(Source: Amended at 16 Ill. Reg. 19879, effective December 7, 1992)

Section 140.32 Prohibition on Participation, and Special Permission for Participation

a) Prohibition on Participation by Terminated, Suspended or Barred Entities

1) Upon being terminated, suspended or barred and while such disability from Medical Assistance Program participation remains in effect, an entity:

A) Cannot be a vendor, assume management responsibility for a vendor, own (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership of a corporate vendor, become an owner of a sole proprietorship that is a vendor, become a partner of a vendor or become an officer of a corporate vendor;

B) Cannot be an employer of a vendor; a person with management responsibility for an employer of a vendor; an officer of an employer of a vendor; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in an employer of a vendor; an owner of a sole proprietorship that employs a vendor; or a partner of a partnership that employs a vendor;

C) Cannot order goods or services from a vendor when payment for such goods or services will be made in whole or in part by the Department;

D) Cannot render goods or services as an employee of a vendor or as an independent contractor with a vendor for which payment will be made in whole or in part by the Department;

E) Cannot, directly or indirectly, serve as a technical or other advisor to a vendor;

F) Cannot, directly or indirectly, be an incorporator or member of the board of directors of a vendor;

G) Cannot, directly or indirectly, be an investor in a vendor; and

H) Cannot own (directly or indirectly) a 5% or greater interest in any premises or equipment leased by a vendor.

2) An individual who is terminated or barred from participation in the Medical Assistance Program cannot transfer the direct or indirect

ownership of a vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

3) After the provision of written notice to the affected parties, the Department may deny payment for goods or services rendered or ordered by an entity that violates the provisions of subsections (a)(1)(A), (B), (C) or (D) of this Section. The Department may also pursue the imposition of all criminal and civil penalties as may be available and necessary.

4) Whenever an entity violates the provisions of subsections (a)(1)(E), (F), (G) or (H) of this Section the Department may refer the matter for filing of an appropriate civil suit by the Attorney General or the State's Attorney to recover all benefits obtained improperly as well as treble damages or $10,000.00 for each such violation whichever amount is greater, in accordance with Section 11-27 of the Public Aid Code [305 ILCS 5/11-27].

b) Special Permission for Continuation or Reinstatement of Medical Assistance Program Participation for Barred Entities

1) Any entity barred pursuant to Section 140.18 may seek special permission to continue participation in the Medical Assistance Program or for reinstatement in the Program.

2) Special permission shall be granted only if the entity seeking such action demonstrates to the Department that it had no part in, and no knowledge of, the conduct which led to the decision to terminate upon which the barring was based or that it had no part in, and notified the Department as soon as it gained knowledge of, the conduct.

3) In deciding whether to authorize the continued participation by, or reinstatement of, an entity that meets the conditions of this subsection (b) the Director shall consider the following factors:

A) Whether the entity requesting special permission demonstrates a fitness to participate in the Medical Assistance Program;

B) The extent to which any legally enforceable debts owed to the Department by the applicant or an entity in which the applicant or

his nominee held a substantial ownership interest have been paid;

C) Any other circumstances reasonably related to the issue of whether the special permission should be granted.

4) Any entity that seeks special permission to continue or reinstate benefits shall submit a written request to the Director. Upon receipt of such a request, the Director or his designee shall review the request and any supporting documentation which accompanies it, and shall notify the entity of the decision within 60 days of receipt of the request, where practicable. In reviewing the request, the Director may require the entity to appear before and cooperate with a peer review committee of the Department.

5) An entity may request special permission only once. An entity that has been denied special permission may not apply for readmission under Section 140.14 for one year after the final decision to deny special permission. An entity that has been denied readmission under Section 140.14 or has an application under Section 140.14 pending with the Department may not apply for special permission.

6) Whenever a barred entity is readmitted to the Medical Assistance Program pursuant to this Section, the Director may make the vendor's continued participation contingent upon compliance with specified restrictions, including, but not limited to:

A) Limiting the participation by the entity as to the location, type, volume or category of goods or services to be provided;

B) Requiring that the entity obtain continuing education, or additional licenses or authorizations; and

C) Any other terms or conditions which may be appropriate or required under the circumstances.

(Source: Amended at 19 Ill. Reg. 2933, effective March 1, 1995)

Section 140.33 Publication of List of Sanctioned Entities

a) The Department shall publish a list of every entity that is currently terminated, suspended or barred from participation in the Medical Assistance Program and shall include every alternate payee that has been revoked, and every entity prohibited from participating with an alternate payee. The list may also include entities that have voluntarily withdrawn from participation in the Medical Assistance Program as a result of a settlement agreement. The list shall also include the period of suspension. The list shall be supplemented with additions and deletions each month, if any. The list shall be published on the Office of the Inspector General's (OIG) website at www.state.il.us/agency/oig.

b) The Department shall, upon request, mail the list and supplements, without charge, to associations and societies of vendors in the Medical Assistance Program, including their affiliates and components. Societies and associations of vendors and other entities that wish to receive the list are responsible for providing the Department with a current mailing address.

c) An entity may file a request, in writing or via e-mail, for a list of any adverse actions against a particular entity that are not currently in effect. Inquiries may be directed to the OIG at 404 North Fifth Street, Springfield, Illinois 62702, or at Oigwebmaster@illinois.gov. The Department shall respond to such a request within ten days after receiving it.

(Source: Amended at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.35 False Reporting and Other Fraudulent Activities

a) Providers are subject to Section 12-15.1 of the Illinois Public Aid Code, pertaining to penalties for vendor fraud and kickbacks.

b) Providers are also subject to Section 1909 (42 USC 1396h) of the Social Security Act that prohibits kickbacks, false reporting and other fraudulent activities, and provides for fines and imprisonment for persons who engage in such activities.

Section 140.40 Prior Approval for Medical Services or Items

a) The Department may impose prior approval requirements as specified by rule, to determine the essentialness of medical care provided in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.

b) In general, in order for prior approval to be granted, items and services must be:

1) non-experimental,

2) appropriate to the client's needs,

3) necessary to avoid institutional care, and

4) medically necessary to preserve health, alleviate sickness, or correct a handicapping condition.

c) Providers are responsible for requesting prior approval for medical services or items. Prior approval requests must include at a minimum:

1) patient name,

2) recipient number,

3) patient age, address, and whether or not the patient resides in a group care facility,

4) identification of the practitioner prescribing or ordering the item or service,

5) diagnosis,

6) description of item or service,

7) treatment plan,

8) how long the service or item will be needed, and

9) purchase or rental cost.

d) To the extent possible, the request should show how the item or service is expected to correct or help the condition, and why the requested treatment plan is

better than any other plan commonly used to deal with similar diagnoses or conditions. Anything unique to the medical condition or living arrangement affecting the choice of a recommended treatment plan or item should be explained.

e) A written notice of disposition of the request for prior approval will be sent to the client within the time limits prescribed below. If the notice of disposition is not sent within the applicable time limit, prior approval will be granted automatically. Oral notification will be given only when a request for medical transportation is approved.

(Source: Amended at 22 Ill. Reg. 19898, effective October 30, 1998)

Section 140.41 Prior Approval in Cases of Emergency

a) In cases of emergency, the provider may request prior approval by telephoning the office that gives such approval. "Emergency" is defined as a condition or situation which threatens the recipient's life or may cause permanent damage, or requires services which, in the opinion of the attending physician, are needed to relieve immediate pain and suffering. If a recipient's condition is so severe that his or her life is endangered and there is not enough time to seek approval by telephone or the service is needed during non-working hours, the service may be provided before obtaining prior approval.

b) When emergency approval is obtained by telephone, or the service is provided before obtaining approval under the above circumstances, the provider must still submit a written request in order to receive approval to bill for the services provided.

Section 140.42 Limitation on Prior Approval

The Department will not give prior approval for an item or service if a less expensive item or service is appropriate to meet the client needs. The Department will not approve purchase of equipment if the client already has equipment which is adequate and sufficient to meet the client's needs. The Department will not approve the purchase of equipment if the Department already owns such equipment and will make it available for the client to use.

Section 140.43 Post Approval for Items or Services When Prior Approval Cannot Be Obtained

a) Post approval may be requested for items or services provided during Department nonworking hours, or nonworking hours of its agents, whichever is applicable, or when a life threatening condition exists and there is no time to call for approval.

b) To be eligible for approval consideration, the requirements for prior approval must be met and post approval requests must be received by the Department or its agents, whichever is applicable, no later than 90 days after the date services or goods are provided. Exceptions to this requirement will be permitted only in the following circumstances:

1) The Department or the Department of Human Services has received the patient's Medical Assistance application, but approval of the application has not been issued, as of the date of service. In such a case, the post approval request must be received no later than 90 days after the date of the Department's Notice of Decision, approving the patient's application.

2) The patient did not inform the provider of his/her eligibility for Medical Assistance. In such a case, the post approval request must be received no later than six months after the date of service, but will be considered for payment only if there is attached to the request a copy of the provider's dated, private pay bill or collection correspondence, which was addressed and mailed to the patient each month following the date of service.

3) A request for payment was submitted to a third party billing within six months following the date of service. In such a case, a post approval request must be received by the Department no later than 90 days after the date of final adjudication by the third party.

(Source: Amended at 28 Ill. Reg. 4958, effective March 3, 2004)

Section 140.44 Withholding of Payments Due to Fraud or Misrepresentation

a) Payments on pending and subsequently submitted bills may be withheld, in whole or in part, to a provider or alternate payee, upon receipt by the Department of evidence from State or Federal law enforcement or Federal oversight agencies or from the results of a preliminary Department audit and determined by the Department to be credible, that the circumstances giving rise to the need for a withholding of payments may involve fraud or willful misrepresentation under the Illinois Medical Assistance Program. For purposes of this Section, "credible evidence" is defined as evidence that reasonable people would agree as being trustworthy and reliable. Payments may be withheld without first notifying the provider or alternate payee of its intention to withhold the payments.

b) The Department must send notice of its withholding within 5 days after taking that action. The notice must set forth the general allegations as to the nature of the withholding, but need not disclose any specific information concerning the ongoing investigation. The notice must also state the following:

1) The payments are being withheld in accordance with 305 ILCS 5/12-4.25 (K).

2) The withholding is for a temporary period; the notice shall cite the circumstances under which withholding will be terminated.

3) When appropriate, the type of claim for which withholding is effective.

4) The provider or alternate payee has the right to submit written evidence for reconsideration of the withholding of payments by the Department.

5) A written request may be made to the Department for full or partial release of withheld payments and the request may be made at any time after the Department first withholds the payments.

c) All withholding of payment actions under this Section shall be temporary and shall not continue after any of the following:

1) The Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider or alternate payee.

2) Legal proceedings related to the provider's or alternate payee's alleged fraud, willful misrepresentation, or violations of Article V of the Illinois Public Aid Code [305 ILCS 5/Art. V] or violations of 89 Ill. Adm. Code: Chapter I are completed. If the Department commences an administrative

proceeding that seeks the termination of the provider or revocation of the alternate payee, withholding will continue in conformance with 89 Ill. Adm. Code 104.272.

3) The withholding of payments for a period of 3 years.

d) The provider or alternate payee request for reconsideration of payment withholding, or request for full or partial release of payments withheld, must be in writing, set out the reasons for the request, and be sent to the Office of Inspector General at 404 North Fifth Street, Springfield, Illinois 62706, or by e-mail to oigwebmaster@illinois.gov. The request may include documentation that the allegations of fraud or willful misrepresentation involving the Medical Assistance Program did not take place.

e) Partial or full release of payments on pending and subsequently submitted bills may be granted, at the discretion of the Inspector General of the Department, when it is in the best interest of the recipients of medical assistance. This may include, but not be limited to, access to medical services for recipients or the potential movement of patients from long term care settings.

(Source: Added at 33 Ill. Reg. 11938, effective August 17, 2009)

Section 140.55 Recipient Eligibility Verification (REV) System

a) REV System Description

The REV system was created under Public Act 88-554 and offers on-line Medicaid eligibility information and claims history information to subscribers. This information is provided to subscribers through contractors who have entered into a contract with the Department. The contractors are responsible for marketing the system to providers. Services will be made available through leased lines between the contractors and the State. Upon availability of REV contractors in a geographic area, only contractors and subscribers participating in the REV system are authorized to access information provided through the REV system.

b) Definitions

As used in this Section, unless the context requires otherwise:

1) Contractors are those entities having successfully completed the Request for Proposal (RFP) process and executed a contract with the Department to provide services under the REV system.

2) Providers are providers of medical services who are enrolled with the Department to render services under the Medicaid program.

3) Subscribers are medical providers who are enrolled in the Medicaid program or are the provider's agent and who execute a contract with a contractor to participate in the REV system.

c) Eligible Contractors

In order to be qualified to participate in the system, the contractor must:

1) Submit a proposal acceptable to the Department and execute a contract with the Department. Under this contract, the contractor must agree to execute a written contract with each subscriber prior to any exchange of data with that subscriber and only after the contractor has received prior approval from the State of the model subscriber contract language;

2) By the end of the first 12 months of the contract, handle a minimum number of subscribers or transactions per month as determined by the Department;

3) Agree to access data through one or more high speed data transmission

circuits as determined by the Department to be compatible with current technology and operating needs;

4) Treat all information, including information relating to recipients and providers obtained by the contractor through performance while under the contract with the Department, as confidential information pursuant to the Public Aid Code;

5) Provide data through a system designed to be flexible to meet each subscriber's needs as well as meeting the following specific requirements:

A) Support various means of telecommunication that are commonly available for use by the subscriber; and

B) Be compatible with the State of Illinois Department of Central Management Services' current telecommunications operating environment;

6) Certify that it is neither an individual nor an organization that:

A) Furnishes statements or bills and receives payment in the name of the providers; or

B) Advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or a deduction of the portion of the accounts receivable.

d) Subscriber Contracts

The contractor must agree that all contracts with subscribers provide that:

1) Access to the system shall be restricted to the sole purpose of verification of medical assistance eligibility and providing claims history information where a subscriber is requesting payment information for medical services rendered to a recipient;

2) The subscriber indemnifies and holds harmless the State, its agents and employees from any and all claims by such subscriber or any recipient who is aggrieved by the actions of any party under the contract;

3) The subscriber is an enrolled Medicaid provider or the provider's agent;

4) The fees charged to subscribers must be reasonable;

5) Any other third party may be granted access to the system only with prior

approval of the State;

6) All information, including information relating to recipients and providers obtained by the subscriber through performance under contract with the contractor, is treated as confidential information pursuant to the Public Aid Code; and

7) The subscriber certifies that neither it, nor any employees, partners, officers or shareholders of the subscriber, are currently barred, suspended or terminated from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for, conviction of any Medicaid or Medicare program offenses.

e) Charges for System Services

1) Charges to contractors will be established in the contract between the contractor and the Department.

2) Charges to the subscribers are made in accordance with the fee schedule and provisions specified in the contractor's and subscriber's contract.

f) Required Subscriber Information

The following recipient information must be made available to the subscriber:

1) Medicaid eligibility status for service date(s);

2) Date of birth;

3) Medicare eligibility;

4) HMO enrollment data;

5) Recipient restriction status;

6) Spend-down status;

7) Recipient claims history information; and

8) Third Party Liability (TPL) information, including:

A) Carrier name and address;

B) Coverage types;

C) Policyholder name and address;

D) Policy number;

E) Group number;

F) Coverage date; and

G) Coverage termination date.

(Source: Added at 20 Ill. Reg. 6929, effective May 6, 1996)

Section 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments

a) C-13 Invoice Voucher Advance Payments

1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department of Public Aid;

B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired; or

ii) cash flow problems encountered by a provider or group of providers which are unrelated to agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional

care;

iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vi) for government-owned facilities, this subsection (a)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) is met; and

vii) for providers who have filed for Chapter 11 bankruptcy, this subsection (a)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met;

D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:

i) specific reason(s) for advanced payments;

ii) specific amount agreed to be advanced;

iii) specific date to begin recoupment; and

iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).

2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.

3) Approval Process

A) In order to obtain C-13 advance payments, providers must submit their request in writing (telefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the circumstances creating the need for the advance payments;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the amount of the advance required.

B) An agreement will be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to release of the warrant.

C) C-13 advance payments shall be authorized for the provider following approval by the Medicaid Administrator or designee. Once all requirements of this subsection (a)(3) are met, the Administrator will authorize payment within seven days.

4) Recoupment

A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.

B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six months from the month in which payment is authorized. For those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.

C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Department pursuing other collection methods.

5) Prior Agreements
The terms of any agreement signed between the provider and the Department prior to the adoption of this rule will remain in effect, notwithstanding the provisions of this Section.

b) Expedited Claims Payments

1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department of Public Aid;

B) have experienced an emergency which necessitates expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to the clients is severely impaired;

ii) cash flow problems encountered by a provider or group of providers which are unrelated to Department technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing

system problems) or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider adversely impacting on the ability to serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

iv) for hospitals that qualify as disproportionate share hospitals as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122 and receive Rehabilitation Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(b)) or Direct Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(c)(1)), a request must be made in writing that demonstrates proof of cash flow problems;

v) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

vi) for sole source pharmacies in a community that are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vii) for government-owned facilities, this subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met; and

viii) for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) may be waived if the cash flow criteria

under subsection (b)(1)(B)(ii) are met.

2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.

3) Approval Process

A) In order to qualify for expedited payments, providers must submit their request in writing (telefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the need for the expedited payments; and

ii) supportive documentation to substantiate the emergency nature of the request.

B) Expedited payments shall be authorized for the provider following approval by the Medicaid Administrator or designee.

C) The Department will periodically review the need for any continued expedited payments.

4) Prior Agreements
The terms of any agreement signed between the provider and the Department prior to the adoption of this rule will remain in effect, notwithstanding the provisions of this Section.

(Source: Amended at 28 Ill. Reg. 2744, effective February 1, 2004)

Section 140.72 Drug Manual (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354)

Section 140.73 Drug Manual Updates

(Source: Recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354)

SUBPART C: PROVIDER ASSESSMENTS

Section 140.80 Hospital Provider Fund

a) Purpose and Contents

1) The Hospital Provider Fund (Fund) was created in the State Treasury on February 3, 2004 (see 305 ILCS 5/5A-8). Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and 305 ILCS 5/5A-4 and 12.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Section;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) Monies transferred from another fund in the State treasury;

E) All other monies received for the Fund from any other source, including interest earned on those monies.

b) Provider Assessments

1) An annual assessment on hospital inpatient services is imposed on each hospital provider in an amount equal to the hospital's occupied bed days multiplied by $84.19 for State fiscal years 2004 and 2005, if the payment methodologies required under 305 ILCS 5/5A-12 and the waiver created under 42 CFR 433.68 are approved with an effective date prior to July 1, 2004; or the assessment will be imposed for fiscal year 2005 only, if the payment methodologies required under 305 ILCS 5/5A-12 and the waiver created under 42 CFR 433.68 are approved with an effective date on or after July 1, 2004. The Department shall use the number of occupied bed days as reported, by February 3, 2004 (the date of enactment of Public Act

93-0659), by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health to calculate the hospital's annual assessment. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals or if there are data errors in the reported sum of a hospital's occupied bed days as determined by the Department, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

2) Subject to the provisions of 305 ILCS 5/5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007 and 2008, in an amount equal to 2.5835 percent of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835 percent of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Department may obtain the hospital provider's adjusted gross hospital revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

3) Subject to Sections 5A-3 and 5A-10 of the Public Aid Code, for State fiscal years 2009 through 2013, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2009 through 2013, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

c) Payment of Assessment Due

1) For State fiscal years through 2008, the annual assessment shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year on the 14th business day of September, December, March and May. The assessment imposed by Section 5A-2 for State fiscal year 2009 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 14th State business day of each month. No installment payments of an assessment shall be due and payable, however, until after:

   A) The Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, whichever is applicable for that fiscal year, have been approved by CMS and any waiver necessary under 42 CFR 433.68 has been granted by CMS; and

   B) For State fiscal years through 2008, the hospital has received payments required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, whichever is applicable for that fiscal year. For State fiscal year 2009 and each subsequent State fiscal year, the Comptroller has issued payments required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, whichever is applicable for that fiscal year.

2) Assessment payments postmarked on the due date will be considered as paid on time. Upon notification to the Department of approval of the payment methodologies to hospitals required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2, and any waiver necessary under 42 CFR 433.68 has been granted by the CMS, all installments otherwise due prior to the date of notification shall be due and payable to the Department upon written direction from the Department and the receipt of the payments required under Section 5A-12, 5A-12.1 or 5A-12.2.

3) Any assessment amount that is due and payable to the Department more frequently than once per calendar quarter shall be remitted to the Department by the hospital provider by means of electronic funds transfer. The Department may provide for remittance by other means if the amount due is less than $10,000 or electronic funds transfer is unavailable for this purpose.

4) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Notice Requirements, Penalty, and Maintenance of Records

1) The Department shall send a notice of assessment to every hospital provider subject to an assessment under subsection (b) of this Section, except that no notice shall be sent until the Department receives written notice that the payment methodologies to hospitals required under 305 ILCS 5/5A-12, 5A-12.1 or 5A-12.2 have been approved and the waiver under 42 CFR 433.68 has been granted by CMS.

2) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate notice shall be sent for each hospital.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) of this Section, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) of this Section by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate or maintain a hospital, the person shall pay the assessment for the year as adjusted (to the extent not previously paid).

2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) of this Section, upon notice by the Department, shall pay the assessment under subsection (d) of this Section as computed by the Department in installments on the due dates stated on the notices and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment notice. For State fiscal years 2006 through 2008, in determining the annual assessment amount for the provider, the Department shall develop hypothetical adjusted gross hospital revenue for the hospital's first full fiscal year, which may be based on the annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior hospital provider of the same hospital during the year. For State fiscal years 2009 through 2013, in the case of a hospital provider that did not conduct, operate or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of

hypothetical occupied bed days for the full calendar year as determined by the Department. The assessment determination made by the Department is final.

3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the State fiscal year shall be annualized based on the provider's actual adjusted gross hospital revenue information for the portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue by the number of days the hospital was in operation and then multiplying the amount by 365). Adjusted gross hospital revenue information reported by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operators. The full quarterly installment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Waiver due to reasonable cause may include but is not limited to:

A) provider has not been delinquent on payment of an assessment due, within the last three calendar years from the time the delinquency occurs.

B) provider can demonstrate to the Department's satisfaction that a

payment was made prior to the due date.

C) provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30 days after the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any interest and penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's rules at 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Medicaid Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Hospitals
The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) The State delays payments to hospitals due to problems related to State cash flow; or

2) A cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the

assessment.

h) Delayed Payment – Individual Hospitals
In addition to the provisions of subsection (g) of this Section, the Department may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) of this Section.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) The provider has experienced an emergency that necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) of this Section would impose severe and irreparable harm to the clients served. Circumstances that may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) that have precluded payments, or that have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) Cash flow problems encountered by a provider that are unrelated to Department technical system problems and that result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) The provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:

i) A hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital (DSH) under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) A government-owned facility that meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section.

iii) A hospital that has filed for Chapter 11 bankruptcy and that meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section.

C) The provider must file a delay of payment request as defined under subsection (h)(3)(A) of this Section, and the request must include a Cash Position Statement that is based upon current assets, current liabilities and other data for a date that is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) The ratio of current assets divided by current liabilities is greater than 2.0.

ii) Cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments that are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) The provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) The provider must sign an agreement with the Department that specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) Specific reasons for institution of the delayed payment provisions;

ii) Specific dates on which payments must be received and the amount of payment that must be received on each specific date described;

iii) The interest or a statement of interest waiver as described

in subsection (h)(5) of this Section that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) A certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) A certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) Such other terms and conditions that may be required by the Department.

2) A hospital that does not meet the above criteria may request a delayed payment schedule. The Department may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the date designated by the Department. Providers will be notified, in writing, as to the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) An explanation of the circumstances creating the need for the delayed payment provisions;

ii) Supportive documentation to substantiate the emergency

nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

iii) Specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section. The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C) of this Section, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) of this Section. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current

delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) of this Section shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions
The Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Department shall administer and enforce 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12 and collect the assessments and penalty assessments imposed under 305 ILCS 5/5A-2 and 4. The Department, its Director, and every hospital provider subject to assessment measured by occupied bed days shall have the following powers, duties, and rights:

1) The Department may initiate either administrative or judicial proceedings, or both, to enforce the provisions of 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12. Administrative enforcement proceedings initiated shall be governed by the Department's rules at 89 Ill. Adm. Code 104.200 through 104.330. Judicial enforcement proceedings initiated shall be governed by the rules of procedure applicable in the courts of this State.

2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than three years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Department and the hospital provider before the expiration of this limitation period.

3) Any unpaid assessment under 305 ILCS 5/5A-2 shall become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of the real property and improvements, the machinery and equipment, or the furniture or fixtures of any hospital that is subject to the provisions of 305 ILCS 5/5A-1, 2, 3, 4, 5, 7, 8, 10 and 12, the seller or transferor shall pay the Department the amount of any assessment, assessment penalty, and interest (if any) due from it under 305 ILCS 5/5A-2 and 4 up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or

transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Department showing that no assessment, penalty, or interest is due from the seller or transferor under 305 ILCS 5/5A-2, 4 and 5.

4) Payments under 305 ILCS 5/5A-4 are not subject to the Illinois Prompt Payment Act. Credits or refunds shall not bear interest.

5) In addition to any other remedy provided for and without sending a notice of assessment liability, the Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Department to the hospital provider.

j) Exemptions
The following classes of providers are exempt from the assessment imposed under 305 ILCS 5/5A-4 unless the exemption is adjudged to be unconstitutional or otherwise invalid:

1) A hospital provider that is a State agency, a State university, or a county with a population of 3,000,000 or more.

2) A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality, hospital district, or any other local governmental unit.

3) For State fiscal years 2004 through 2013, a hospital provider, described in section 1903(w)(3)(F) of the Social Security Act, whose hospital does not charge for its services is exempt from the assessment imposed by Section 5A-2 of the Public Aid Code.

4) For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital.

5) For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital.

6) For State fiscal years 2004 and 2005, a hospital provider whose hospital is not a psychiatric hospital, rehabilitation hospital, or a children's hospital and has an average length of inpatient stay greater than 25 days.

k) Nothing in 305 ILCS 5/5A-4 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before February 3, 2004.

l) Definitions.
As used in this Section, unless the context requires otherwise:

1) "Adjusted gross hospital revenue for inpatient services" means inpatient gross revenue less Medicare gross inpatient revenue, which shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the HCRIS file for the quarter ending December 31, 2004, without regard to any subsequent adjustments or changes to that data.

2) "Adjusted gross hospital revenue for outpatient services" means outpatient gross revenue less Medicare gross outpatient revenue, which shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the HCRIS file for the quarter ending December 31, 2004, without regard to any subsequent adjustments or changes to such data.

3) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

4) "Department" means the Illinois Department of Healthcare and Family Services.

5) "Fund" means the Hospital Provider Fund.

6) "HCRIS" means the federal Centers for Medicare and Medicaid Services Healthcare Cost Report Information System.

7) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

8) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited

liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

9) "Inpatient Gross Revenue" means total inpatient gross revenue, as reported on the HCRIS Worksheet C, Part 1, Column 6, Line 101, less the sum of the following lines (including any subset lines of these lines):

A) Line 34: Skilled Nursing Facility.

B) Line 35: Other Nursing Facility.

C) Line 35.01: Intermediate Care Facility for the Mentally Retarded.

D) Line 36: Other Long Term Care.

E) Line 45: PBC Clinical Laboratory Services – Program Only.

F) Line 60: Clinic.

G) Line 63: Other Outpatient Services.

H) Line 64: Home Program Dialysis.

I) Line 65: Ambulance Services.

J) Line 66: Durable Medical Equipment – Rented.

K) Line 67: Durable Medical Equipment – Sold.

L) Line 68: Other Reimbursable.

10) "Medicare bed days" means, for each hospital, the sum of the number of days that each bed was occupied by a patient who was covered by Title XVIII of the Social Security Act, excluding days attributable to the routine services provided to persons receiving skilled or intermediate long term care services. Medicare bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

11) "Medicare Gross Inpatient Revenue" means the sum of the following:

A) The sum of the following lines from the HCRIS Worksheet D-4, Column 2 (excluding the Medicare gross revenue attributable to

the routine services provided to patients in a psychiatric hospital, a rehabilitation hospital, a distinct part psychiatric unit, a distinct part rehabilitation unit or swing beds):

i) Line 25: Adults and Pediatrics.

ii) Line 26: Intensive Care Unit.

iii) Line 27: Coronary Care Unit.

iv) Line 28: Burn Intensive Care Unit.

v) Line 29: Surgical Intensive Care Unit.

vi) Line 30: Other Special Care Unit.

B) From Worksheet D-4, Column 2, the amount from Line 103 less the sum of Lines 60, 63, 64, 66, 67 and 68 (and any subset lines of these lines).

C) The amount from Worksheet D-6, Part 3, Column 3, Line 53.

12) "Medicare Gross Outpatient Revenue" means the amount from the HCRIS Worksheet D, Part V, Line 101, Columns 5, 5.01, 5.02, 5.03 and 5.04 less the sum of Lines 45, 60, 63, 64, 65, 66 and 67 (and any subset lines of these lines).

13) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding beds classified as long term care beds and assessed a licensed bed fee during calendar year 2001. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

14) "Outpatient Gross Revenue" means the amount from the HCRIS Worksheet C, Part I, Column 7, Line 101 less the sum of lines 45, 60, 63, 64, 65, 66, 67 and 68 (and any subset lines of these lines).

(Source: Amended at 33 Ill. Reg. 209, effective December 29, 2008)

Section 140.82 Developmentally Disabled Care Provider Fund

a) Purpose and Contents

1) The Developmentally Disabled Care Provider Fund was created in the State Treasury on July 1, 1992, July 14, 1993 and July 1, 1995 (see 305 ILCS 5/5C-7). Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and 305 ILCS 5/5C-2 and 7.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Section;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon; and

E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

b) Provider Assessments
Beginning on July 1, 1993, an assessment is imposed upon each developmentally disabled care provider in an amount equal to six percent, or the maximum allowed under federal regulation, whichever is less, of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. The revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data. Effective January 1, 2008, the tax rate, allowed under federal regulation at 42 CFR 433.68(f)(3)(i), is 5.5 percent.

c) Payment of Assessment Due

1) The assessment described in subsection (b) of this Section shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the due dates. Assessment payments postmarked on the due date will be considered paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) of this Section shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) of this Section a penalty assessment equal to 25 percent of the assessment imposed for the year.

3) Every developmentally disabled care provider subject to an assessment under subsection (b) of this Section shall keep records and books that will permit the determination of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsection (d)(5) or (6) of this Section, an amended assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within 30 days after the close of such externally performed financial audits. If the provider's year end does not coincide with the June 30 ending date for the assessment report, the provider must submit all financial audits covering the tax report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial tax report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility for which the person is subject to assessment under subsection (b) of this Section, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) of this Section by a fraction, the numerator of which is the number of months in the year

during which the provider conducts, operates, or maintains the facility and the denominator of which is 12. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility for which the person is subject to assessment under subsection (b) of this Section shall file an initial return for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) of this Section as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Fiscal Year Operation Adjustment. For a developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of months the facility was in operation and then multiplying that amount by 12). Developmentally disabled care revenue realized by a prior provider from the same facility during the fiscal year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay

any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any facility that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Reasonable cause may include but is not limited to:

A) a provider who has not been delinquent on payment of an assessment due within the last three calendar years from the time the delinquency occurs;

B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or

C) that the provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30 days after the due date, the Department may begin recovery actions against delinquent facilities participating in the Medicaid Program. Payments may be withheld from the facility until the entire provider assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's rules at 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section will continue to accrue during the recoupment process. Recoupment proceedings against the same facility two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the facility does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the assessment due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Facilities
The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State cash flow; or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Facilities
In addition to the provisions of subsection (g) of this Section, the Department may delay assessments for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) of this Section.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) of this Section would impose severe and irreparable harm to the clients served. Circumstances that may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) that have precluded payments, or that have caused

erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility that are unrelated to Department technical system problems and that result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance;

ii) a government-owned facility, that meets the cash flow criteria under subsection (h)(1)(A)(ii) of this Section.

iii) a provider who has filed for Chapter 11 bankruptcy that meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section.

C) the facility must file a delay of payment request as defined in subsection (h)(3)(A) of this Section, and the request must include a Cash Position Statement that is based upon current assets, current liabilities and other data for a date that is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short-term investments and long-term investments equal or exceed the total of accrued wages payable and the assessment payment. Long-term investments that are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for

dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow the assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department that specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment that must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) of this Section that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility that does not meet the criteria listed in subsection (h)(1) may request a delayed payment schedule. The Department may approve the request, notwithstanding the facility not meeting the above criteria, upon a

sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the

terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section. The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C) of this Section, is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B) of this Section. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) of this Section shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions
The Department shall administer and enforce 305 ILCS 5/5C-6 and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in 305 ILCS 5/5C shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before July 1, 1995.

k) Definitions

1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care

revenue. Adjusted gross developmentally disabled care revenue must be reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the facility's last two cost reports.

2) "Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by third party payors or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowance" does not mean any Provider Participation fees/taxes paid to the Department.

3) "Department" means the Illinois Department of Healthcare and Family Services.

4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.

6) "Facility" means all intermediate care facilities as defined under "Developmentally disabled care facility" (subsection (k)(4)).

7) "Fund" means the Developmentally Disabled Care Provider Fund.

(Source: Amended at 32 Ill. Reg. 7727, effective May 5, 2008)

Section 140.84 Long Term Care Provider Fund

a) Purpose and Contents

1) The Long Term Care Provider Fund was created in the State Treasury on July 1, 1992, July 14, 1993 and July 1, 1995 (see 305 ILCS 5/5B-8). Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and 305 ILCS 5/5B-2 and 8.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Section;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon;

E) All monies transferred from the Medicaid Long Term Care Provider Participation Fee Trust Fund; and

F) All monies transferred from the Tobacco Products Tax Act.

b) License Fee

Beginning on July 1, 1993, a nursing home license fee is imposed upon each nursing home provider in an amount equal to $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. All nursing beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing-beds, as defined in subsection (k)(8) of this Section will be used to calculate the licensed nursing bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. Changes in the number of licensed nursing beds will be reported to the Department quarterly, as described in subsection (d)(1) of this

Section. The Department reserves the right to audit the reported data.

c) Payment of License Fee Due

1) The license fee described in subsection (b) of this Section shall be due and payable in quarterly installments, on September 10, December 10, March 10, and June 10 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. License fee payments postmarked on the due date will be considered as paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

3) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their license fee obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 USC 1396), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days after the final approval of the county budget;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by an amount determined by the amount certified and the number of months remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services

pertaining to the certification of county funds.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) On or before the due dates described in subsection (c)(1) of this Section, each nursing home provider subject to a license fee under subsection (b) of this Section shall file a report with the Department reflecting any changes in the number of licensed nursing beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b) of this Section, all changes in licensed nursing beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed nursing beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Public Aid with the licensed nursing bed change form. If a nursing home provider operates or maintains more than one nursing home, a separate report shall be filed for each facility. In the case of a nursing home provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the nursing home provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee imposed in subsection (b) of this Section a penalty fee equal to 25 percent of the license fee imposed for the year.

3) Every nursing home provider subject to a license fee under subsection (b) of this Section shall keep records and books that will permit the determination of licensed nursing bed days on a quarterly basis. All such books and records shall be maintained for a minimum of three years following the filing date of the license fee report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended License Fee Reports. With the exception of amended license fee reports filed in accordance with subsection (d)(5) of this Section, an amended license fee report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual

license fee amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Reconsideration of Adjusted License Fee. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment license fee was due, changes the license fee liability of a nursing home provider, the nursing home provider may request a review or reconsideration of the adjusted license fee within 30 days after the Department's notification of the change in license fee liability. Requests for reconsideration of the license fee adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the quarter in which the license fee is being paid and the closure date has been set. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) of this Section, and for which the closure date for the facility has been set, shall file a final report with the Department on or before the due date for the quarter in which the closure is to occur. The report will reflect the adjusted number of days the facility is open during the reporting quarter and shall be submitted with the final quarterly payment. Example: A facility is set to close on September 24. On or before the due date for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of operation (July 1 through September 24) and the corresponding quarterly license fee payment.

2) Cessation of business after the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) of this Section, and for which closure occurs after the due date for the reporting quarter, but prior to the last day of the reporting quarter, shall file an amended final report with the Department within 30 days after the closure date. The amended report will reflect the number of days the facility was operational during the reporting quarter and the revised license fee amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes on December 27. An amended report reflecting 88 days, the actual

number of days the facility was operational during the quarter (October 1 through December 27), must be filed with the Department.

3) Cessation of business prior to the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) of this Section, and for which closure occurs prior to the due date for the reporting quarter, shall file a final report with the Department within 30 days after the closure date. The final report will reflect the number of days the facility was operational during the reporting quarter and the corresponding final license fee amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment for the facility.

4) Commencing of business during the fiscal year in which the license fee is being paid. A nursing home provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee imposed under subsection (b) of this Section shall file an initial report for the reporting quarter in which the commencement occurs within 30 calendar days thereafter and shall pay the license fee under subsection (d) of this Section.

5) Change in Ownership and/or Operators. The full quarterly assessment/license fee must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment/license fee amount (including past due assessment/license fees and any interest or penalties that may have accrued against the amount) rests on the nursing home provider currently operating or maintaining the nursing facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any nursing home provider that fails to pay the full amount of an

installment when due, or fails to report a change in licensed nursing beds approved by the Department of Public Health prior to the due date of the installment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Reasonable cause may include but is not limited to:

A) a provider who has not been delinquent on payment of an assessment due, within the last three calendar years from the time the delinquency occurs;

B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or

C) that the provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30 days after the due date, the Department may begin recovery actions against delinquent nursing home providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license fee, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if a provider fails to comply with an agreement the Department reserves the right to recover any outstanding license fee, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's rules at 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section will continue to accrue during the recoupment process. Recoupment proceedings against the same nursing home provider two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the nursing home provider does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims

processing system, within three months after the license fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities
The Department may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State cash flow; or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment - Individual Facilities
In addition to the provisions of subsection (g) of this Section, the Department may delay license fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the license fee was to have been received by the Department as described in subsection (c) of this Section.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) of this Section would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are

unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance;

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(l)(A)(ii) of this Section.

iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criterion under subsection (h)(1)(A)(ii) of this Section.

C) the facility must file a delay of payment request as defined under subsection (h)(3)(A) of this Section and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of license fee payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the license fee payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) of this Section that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility that does not meet the above criteria may request a delayed payment schedule. The Department may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section; a denial of application to borrow the license fee as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the license fee due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to

meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section. The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(l)(C) of this Section, is l.5 or less and the facility meets the criteria in subsections (h)(l)(A) and (B) of this Section. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(l)(E) of this Section.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) of this Section shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions
The Department shall administer and enforce 305 ILCS 5/5B-7, and collect the license fees, interest, and penalty fees imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in 305 ILCS 5/5B shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before July 1, 1995.

k) Definitions
As used in this Section, unless the context requires otherwise:

1) "Department" means the Illinois Department of Public Aid.

2) "Fund" means the Long-Term Care Provider Fund.

3) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether

the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

4) "Licensed nursing bed days" means, with respect to a nursing home provider, the sum for all nursing beds, with the exception of swing-beds, as described in subsection (k)(8) of this Section, of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act or the Hospital Licensing Act.

5) "Nursing home" means a skilled nursing or intermediate long-term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning on Title XIX of the Social Security Act.

6) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long-term care services; or a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act.

7) "Person" means, in addition to natural persons, any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

8) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42

CFR 413.114, October 1, 1991).

(Source: Amended at 28 Ill. Reg. 14804, effective October 27, 2004)

Section 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund

a) Purpose and Contents

1) Effective June 30, 1992, the provider participation fee methodology created under subsection (b) of this Section terminates in accordance with Public Act 87-861. All other provisions of this Section remain in effect, including but not limited to, subsection (f) of this Section on penalties and subsection (l) of this Section on annual audit and reconciliation.

2) The Funds were created in the State Treasury upon enactment of Public Act 87-13. Interest earned by the Funds shall be credited to the appropriate Fund. The Funds shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

3) The Funds are created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-13.

4) The Funds shall consist of:

A) All monies collected or received by the Department under subsections (b) below;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Funds;

C) Any interest or penalty levied in conjunction with the administration of the Funds; and

D) All other monies received for the Funds from any other source, including interest earned thereon.

b) Provider Participation Fees

Beginning on July l, l99l, a fee is imposed upon each facility in an amount equal to l5% of the facility's gross receipts for services provided for the previous State fiscal year as determined and reported by the Department.

c) Payment of Fees Due

1) The fees described in subsection (b) above shall be due and payable on a

calendar quarterly basis.

2) The fees shall be payable to and collected by the Department in quarterly amounts due and received by the Department at the address specified on the Provider Participation Fee Notice described in subsection (d) below on the first business day of the first calendar quarter following the quarter for which the fee is being paid, with the exception of the initial payment which shall be due within thirty (30) days of the date of the Department's notification of the fee due. The subsequent quarterly amounts shall be due on January l, April l, July l and October l of each year. All monies collected under subsections (b) and (c) of this Section shall be deposited into the appropriate Fund. For facilities which sign an amendment to their provider agreement stating they will be terminating operation at a specific point in time, the Department will make an adjustment in the fee based on a quarterly average public assistance occupancy level.

3) All payments received by the Department shall be credited first to any interest or penalty, and then to the fee due.

4) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their fee obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the fee. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days of the final approval of the county budget. However, for state fiscal year l992, the county budgets covering the periods December l, l990 through November 30, l99l and December l, l99l through November 30, l992 must be submitted;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability

amount. This amount will be reduced by one twelfth of the annual assessment amount prior to payment as a certification statement was provided in lieu of an actual assessment payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.

d) Notification

The Department shall notify each facility of the results of its calculations under subsections (b) and (c) above. The notification shall be in writing and shall be submitted to the facility at least 30 days prior to the date on which the provider participation fee is due. Such calculations shall be subject to quarterly reconciliations as described in subsection (e) below and the annual audit/reconciliation described in subsection (l) below.

e) Procedure for Reconsideration and Quarterly Reconciliation

1) Reconsiderations. Upon notification of the results of the Department's calculations under subsections (b) and (c) above, each facility shall have the right to reconsideration of the calculation of its provider participation fee for that quarter. Only requests for reconsideration of the assessment calculation shall be considered during the quarterly reconciliation period. All appeals based on utilization/spending estimates shall be addressed during the annual audit/reconciliation described in subsection (k) below.

A) Requests for reconsideration must be received in writing within 30 calendar days of the date of the Department's notification of the fee due. The request shall be accompanied by written materials setting forth the grounds for reconsideration.

B) A facility shall be required to pay its provider participation fee amount for the time period in question. In the event that a request for reconsideration results in the need for an adjustment to the fee due for the subject quarter, such adjustment shall be made during the quarterly reconciliation for the subject quarter.

2) Quarterly Reconciliation. A quarterly reconciliation shall be performed by the Department to make adjustments to the fees calculated by the Department under subsections (b) and (c) above. During the quarterly reconciliation, the Department shall consider all requests for reconsideration which are received in compliance with subsection (e)(l)

above. The Department shall notify each facility of the results of the quarterly reconciliation. The notification shall be in writing and shall be submitted to the facility at least ten (l0) working days prior to the date on which the subsequent provider participation fee is due. If as a result of the reconciliation, the Department determines that the amount of the reconsidered fee was incorrect, this notification shall include an adjustment to the amount of the provider participation fee which is next due. The facility shall be obligated to pay the amount shown on the reconciliation notification if that amount differs from the amount in the notification described in subsection (d) above.

f) Penalties

1) Any facility that fails to pay the fee when due or pays less than the full amount due as described in subsections (b) and (c) above, shall be assessed a penalty of ten (10%) percent of the delinquency or deficiency for each month, or fraction thereof, computed on the full amount of the delinquency or deficiency, which includes any penalty accrued and not paid, from the time the fee was due.

2) Within five days from the due date, the Department will begin immediate recoupment actions against the delinquent facility by withholding the amount due from future payments. No payments will be made to the facility until the entire provider fee, including any penalties, is satisfied. Recoupment proceedings against the same facility two times in a fiscal year shall be cause for termination from the Program.

3) If the facility is no longer doing business with the Department or the Department cannot recover the full amount due, including penalties and interest, within three months of the fee due date, the Department may begin legal action to recover the monies owed plus court costs.

4) The Director of the Department of Public Aid is authorized to establish delayed payment schedules for individual facilities that are unable to make timely payments under this Section due to financial difficulties. The delayed payment provisions are described in subsections (g) and (h) below.

g) Delayed Payment – Groups of Facilities.
The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when

1) the State delays payments to facilities due to problems related to state cash flow, or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the fee.

h) Delayed Payment – Individual Facilities
In addition to the provisions of subsection (g) above, the Director may waive or delay fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter in which the provider participation fee was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances to qualified facilities of medical assistance services. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance;

ii) for government-owned facilities, subsection (h)(l)(B)(i) may be waived if the cash flow criteria under subsection (h)(l)(A)(ii) is met; and

iii) for providers who have filed for Chapter 11 bankruptcy, subsection (h)(1)(B)(i) may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) is met.

C) the facility must file a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than sixty (60) days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow provider participation fee funds through a cash flow bond pool or financial institutions such as a commercial bank.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment

provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received within ten (10) working days of the date of the Department's notification of the provider participation fee due for the subject quarter as described in subsection (c) above. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax

requests must be followed up with original written requests by certified mail postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) above may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet the terms and conditions of the agreement. In the event the facility fails to meet the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(l)(C) above is l.5 or less and the facility meets the criteria in (h)(l)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(l)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has

requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied. The waiver of penalties described in subsection (h)(3) above shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Disbursements from the Fund

1) Disbursements from the Funds shall be made only:

A) for facility expenditures made under Title XIX of the Social Security Act;

B) for the reimbursement of monies collected by the Department from facilities through error or mistake;

C) for payment of administrative expenses incurred by the Department or its agent in performing the activities authorized by subsections (b), (c), (d), (e) and (f) above; and

D) for payments of any amounts which are reimbursable to the federal government for payments from these Funds which are required to be paid by State warrant. Disbursements from these Funds shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department.

2) Disbursements from the Fund are conditional on:

A) expiration of the time limitations for reconsiderations requested by facilities under subsection (e)(1) above; and

B) the availability of sufficient monies in the Funds to make the payments required after the quarterly reconciliation determined under subsection (e)(2) above and the annual audit reconciliation determined under subsection (l) below.

j) Court Orders. If one or more facilities file suit in any court challenging any part of this Section, payments to facilities under this Section shall be made only to the extent that sufficient monies are available in the appropriate Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the Court.

k) Federal Approval. Payments under the disbursement methodology described in this Section are subject to approval by the federal government in an appropriate State plan amendment. Fees under this Section are conditioned on the disbursement methodology being approved by the federal government in an appropriate State plan amendment.

l) Annual Audit/Reconciliation

1) The Department shall conduct an annual review and reconciliation of the provider participation fees paid by facilities within 9 months from the end of the State fiscal year in which the fee described in subsection (b) of this Section is due. The purpose of the reconciliation shall be to adjust the provider participation fees paid by a facility to reflect:

A) the actual services provided by the facility to clients of the Medical Assistance Program during the period to which the provider participation fee relates; and

B) the payments actually received by the facility related to those services during the period to which the provider participation fee relates

2) Where the estimated utilization of services or gross receipts as determined and utilized by the Department in the calculation of fees due under subsection (b) does not reflect the facility's actual utilization or actual gross receipts during the period to which the provider participation fee relates, the Department shall recalculate the facility's provider participation fee in accordance with subsection (b), using the facility's actual utilization and actual gross receipts for the period to which the provider participation fee relates.

A) If the recalculation indicates that the facility should have been required to pay, but did not pay, a higher provider participation fee based upon actual utilization, the facility shall be required to pay to the Fund within 60 days of the date of notification from the Department that monies are owed to the Department, the difference between the provider participation fee amount actually paid and the provider participation fee amount which should have been paid.

B) If the recalculation indicates that the facility paid a total provider participation fee during the twelve-month period which exceeded that which the facility should have been required to pay based upon actual utilization, the Department shall refund within 60 days

of the date of notification from the Department that monies are due the facility to the facility the difference between the amount the facility actually paid and the amount of the provider participation fee the facility should have paid.

3) In no event shall the payments to a facility, less the fees paid by the facility under subsections (b) and (c) above, equal less than the payments from the facility's State fiscal year 1991 weighted average payment rates reduced by 5% unless current rates are lowered by the Inspection of Care survey or rates are reduced due to lowered costs as reported in the cost report used to calculate the current rate.

4) Amounts recovered from a facility shall be credited to the appropriate Fund. A facility is entitled to recover amounts paid to the Department and to receive refunds and payments from the Department under this Section only to the extent that monies are available in the appropriate Fund.

5) Upon notification of the results of the Department's annual audit/reconciliation, each facility shall have the right to reconsideration of the results of such annual audit/ reconciliation. Such requests for reconsideration must be received in writing within thirty (30) calendar days of the date of the Department's notification of the fee due. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the facility of the results of the review within 30 days of the receipt of all required review material. If the facility fails to request a reconsideration pursuant to this subsection, the Department's determination shall be final.

m) Applicability

The requirements of this Section shall apply only as long as federal funds under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) are available to match the fees collected and disbursed under this Section and only as long as reimbursable expenditures are matched at the Federal Medicaid percentage of a least 50 percent. Whenever the Department is informed that federal funds are not available for these purposes, or shall be available at a lower percentage, this Section shall no longer apply and the Department shall promptly refund to each facility the amount of money currently in the Funds that has been paid by the facility, plus any investment earnings on that amount.

n) Definitions

1) "Actual gross receipts" means the gross receipts, as determined and

reported by the Department, for services provided during the previous fiscal year which have been paid within nine (9) months from the end of such previous State fiscal year (for example, services provided in fiscal year 1991 and paid no later than March 31, 1992, for fees described in subsection (b) which are imposed in State fiscal year 1992; services provided in fiscal year 1992 and paid no later than March 31, 1993, for fees described in subsection (b) of this Section which are imposed in State fiscal year 1993; etc.).

2) "Actual utilization" means the actual utilization of services provided during the State fiscal year in which the fee described in subsection (b) is due and which have been paid within nine (9) months from the end of such State fiscal year (for example, services provided in fiscal year 1992 and paid no later than March 31, 1993 for fees imposed in State fiscal year 1992; services provided in fiscal year 1993 and paid no later than March 31, 1994 for fees imposed in State fiscal year 1993; etc.).

3) "Estimated rate year utilization" means the facility's project utilization for the State fiscal year in which the fee described in subsection (b) of this Section is due (for example, fiscal year 1992 for fees imposed in State fiscal year 1992, fiscal year 1993 for fees imposed in State fiscal year 1993, etc.).

4) "Facility" means a Medicaid certified intermediate care facility for the developmentally disabled or intermediate care facility for the developmentally disabled of l6 beds or less, skilled or intermediate nursing facility, including county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code, but shall not include state-operated facilities or campus facilities as defined in Section 140.583.

5) "Fee" means a provider participation fee paid by facilities under this Section.

6) "Fund" means the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund and/or Medicaid Long Term Care Provider Participation Fee Trust Fund.

7) "Gross Receipts" means all annualized payments for medical services delivered under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and Article V of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-1 et seq.) and shall mean any and all payments made by the Department, or a Division thereof, to a facility certified to participate in the Medical Assistance Program, for services rendered eligible for

Medical Assistance under Article V of the Public Aid Code, State regulations and the federal Medicaid Program as defined in Title XIX of the Social Security Act and federal regulations.

(Source: Amended at 17 Ill. Reg. 3421, effective February 19, 1993)

Section 140.95 Hospital Services Trust Fund

a) Purpose and Contents.

1) Effective June 30, 1992, the provider participation fee methodology created under subsections (b)(1), (2), and (3) of this Section terminates in accordance with Public Act 87-861. All other provisions of this Section remain in effect, including but not limited to, subsection (f) on penalties and subsection (l) on annual audit and reconciliation.

2) The Hospital Services Trust Fund ("Fund") was created in the State Treasury upon enactment of Public Act 87-13. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

3) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section.

4) The Fund shall consist of:

A) All monies collected or received by the Department under subsections (b)(1), (b)(2) and (b)(3) below;

B) All federal matching funds received by the Illinois Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund; and

D) All other monies received for the Fund from any other source, including interest earned thereon.

b) Provider Participation Fees.

1) Beginning on July 1, 1991, and ending on June 30, 1995, a fee is imposed upon each hospital in an amount equal to 50 percent of the positive difference between the hospital's anticipated annualized Medicaid spending, which shall be calculated using the estimated rate year utilization, for State fiscal year 1992 and each State fiscal year thereafter through State fiscal year 1995 excluding payments under 89 Ill. Adm. Code 148.120 and Section 5-5.02 of the Public Aid Code (Ill. Rev. Stat.

1989, ch. 23, par. 5-5.02), and the hospital's total Medicaid base year spending. This fee shall be adjusted pursuant to the annual audit described in subsection (l) below to reflect actual annualized Medicaid spending and actual rate year utilization.

2) Beginning on July 1, 1991, and ending on June 30, 1995, a fee is imposed upon each hospital in an amount equal to 5 percent of the hospital's gross receipts for services provided during the previous State fiscal year as determined and reported by the Department. This fee shall be adjusted pursuant to the annual audit described in subsection (l) below to reflect actual Medicaid gross receipts for services provided during the previous State fiscal year.

3) Beginning on July 1, 1991, and ending on June 30, 1995, a fee is imposed upon each hospital which receives critical care access payments under subsection (d) of Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8). This fee is equal to fifty (50) percent of the critical care payments as calculated in accordance with 89 Ill. Adm. Code 148.120(k).

c) Payment of Fees Due.

1) The fees described in subsection (b) above and shall be due and payable on a calendar quarterly basis.

2) The fees shall be payable to and collected by the Illinois Department in quarterly amounts due and received by the Department at the address specified on the Provider Participation Fee Notice described in subsection (d) on the first business day of the first calendar quarter following the quarter for which the fee is being paid, with the exception of the initial payment which shall be due on November 1, 1991. The subsequent quarterly amounts shall be due on January 1, April 1, July 1, and October 1 of each year with the final payment due on July 1, 1995. All monies collected under subsections (b) and (c) of this Section shall be deposited into the Fund.

3) All payments received by the Department shall be credited first to any interest, second to any penalty, and then to the fee due.

d) Notification.

The Department shall notify each hospital of the results of its calculations under subsections (b) and (c) above. The notification shall be in writing and shall be submitted to the hospital at least thirty (30) days prior to the date on which the

provider participation fee is due. Such calculations shall be subject to quarterly reconciliations as described in subsection (e) below and the annual audit/reconciliation described in subsection (l) below.

e) Procedure for Reconsideration and Quarterly Reconciliation.

1) Reconsiderations. Upon notification of the results of the Department's calculations under subsections (b) and (c) above, each hospital shall have the right to reconsideration of the calculation of its provider participation fee for that quarter. Only requests for reconsideration of the assessment calculation shall be considered during the quarterly reconciliation period. All appeals based on utilization/spending estimates shall be addressed during the annual audit/ reconciliation described in subsection (l) below.

A) Requests for reconsideration must be received in writing within 30 calendar days of the date of the Department's notification of the fee due. The request shall be accompanied by written materials setting forth the grounds for reconsideration.

B) A hospital shall be required to pay its provider participation fee amount for the time period in question. In the event that a request for reconsideration results in the need for an adjustment to the fee due for the subject quarter, such adjustment shall be made during the quarterly reconciliation for the subject quarter.

2) Quarterly Reconciliation. A quarterly reconciliation shall be performed by the Department to make adjustments to the fees calculated by the Department under subsections (b) and (c) above. During the quarterly reconciliation, the Department shall consider all requests for reconsideration which are received in compliance with subsection (e)(1) above. The Department shall notify each hospital of the results of the quarterly reconciliation. The notification shall be in writing and shall be submitted to the hospital at least ten (10) working days prior to the date on which the subsequent provider participation fee is due. If as a result of the reconciliation, the Department determines that the amount of the reconsidered fee was incorrect, the notification shall include an adjustment to the amount of the provider participation fee which is next due. The facility shall be obligated to pay the amount shown on the reconciliation notification if that amount differs from the amount in the notification described in subsection (d) above.

f) Penalties.

1) Any hospital that fails to pay the fee when due or pays less than the full amount due as described in subsections (b) and (c) above, shall be assessed a penalty of ten (10) percent of the delinquency or deficiency for each month, or fraction thereof, computed on the full amount of the delinquency or deficiency, which includes any penalty accrued and not paid, from the time the fee was due.

2) Within five days from the due date, the Department will begin immediate recoupment actions against the delinquent provider by withholding the amount due from future payments. No payments will be made to the provider until the entire provider fee including any penalties is satisfied. Recoupment proceedings against the same provider two times in a fiscal year shall be cause for termination from the program.

3) If the provider is no longer doing business with the Department or the Department can not recover the full amount due including penalties and interest within three months of the fee due date, the Department may begin legal action to recover monies owed plus court costs.

4) The Director of the Department of Public Aid may establish delayed payment schedules for individual facilities that are unable to make timely payments under this Section due to financial difficulties. The delayed payment provisions are described in subsections (g) and (h) below.

g) Delayed Payment – Groups of Facilities

The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) the State delays payments to hospitals due to problems related to state cash flow, or

2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the fee.

h) Delayed Payment – Individual Facilities
In addition to the provisions of subsection (g) above, the Director may waive or delay fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter in which the provider

participation fee was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances to qualified providers of medical assistance services. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems. These situations include cash flow problems which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) the provider serves a significant number of clients under the medical assistance program. Significant in this instance means:

i) that the hospital must qualify as a disproportionate share hospital under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(4).

ii) for government-owned facilities, subsection (h)(1)(B)(i) above may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) above is met; and

iii) for providers who have filed for Chapter 11 bankruptcy, subsection (h)(1)(B)(i) above may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) above is met.

C) the provider must file a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than sixty (60) days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0.

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) the provider must show evidence of denial of an application to borrow provider participation fee funds through a cash flow bond pool or financial institutions such as a commercial bank.

E) the provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement; and

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process.

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received within ten (10) working days of the date of the Department's notification of the provider participation fee due for the subject quarter as described in subsection (c) above. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests by certified mail, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other

authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) above may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet on the terms and conditions of the agreement. In the event the provider fails to meet on the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) above. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(D) above.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the

terms and conditions of any current delayed payment agreement have been satisfied. The waiver of penalties described in subsection (h)(3) above shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Disbursements from the Fund.

1) Disbursements from the Fund shall be made only:

A) for hospital inpatient, hospital ambulatory care, and disproportionate share distributive expenditures made under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

B) for the reimbursement of monies collected by the Department from hospitals through error or mistake;

C) for payment of administrative expenses incurred by the Department or its agent in performing the activities authorized by subsections (b), (c), (d), (e) and (f) above; and

D) for payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant. Disbursements from this Fund shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department.

2) Disbursements from the Fund are conditional on:

A) expiration of the time limitations for reconsiderations requested by hospitals under subsection (e)(1) above.

B) the availability of sufficient monies in the Fund to make the payments required by Section 14-8 of the Public Aid Code after the quarterly reconciliation determined under subsection (e)(2) above, and the annual audit reconciliation determined under subsection (l) below.

j) Court Orders.
If one or more hospitals file suit in any court challenging any part of this Section, payments to hospitals under this Section shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the court.

k) Federal Approval.
Payments under the disbursement methodology described in Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8) are subject to approval by the federal government in an appropriate State plan amendment. Fees under this Section are conditioned on the disbursement methodology described in Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8) being approved by the federal government in an appropriate State plan amendment.

l) Annual Audit/Reconciliation.

1) The Department shall conduct an annual review and reconciliation of the provider participation fees paid by hospitals. The purpose of the reconciliation shall be to adjust the provider participation fees paid by a hospital to reflect:

A) the actual services provided by the hospital to recipients of the Medical Assistance Program, and

B) the payments actually received by the hospital related to those services during the period to which the provider participation fee relates.

2) Where the estimated rate year utilization, anticipated annualized Medicaid spending or gross receipts as determined and utilized by the Department in the calculation of fees due under subsections (b)(1) and (b)(2) above do not reflect the hospital's actual rate year utilization, actual annualized Medicaid spending or actual gross receipts during the period to which the provider participation fee relates, the Department shall recalculate the hospital's provider participation fee in accordance with subsection (b) above, utilizing the hospital's actual rate year utilization, actual annualized Medicaid spending and actual gross receipts for the period to which the provider participation fee relates.

A) If the recalculation indicates that the hospital should have been required to pay, but did not pay, a higher provider participation fee based upon actual rate year utilization, actual annualized Medicaid spending or actual gross receipts during the period to which the provider participation fee relates, the hospital shall be required to pay to the Fund within 60 days of the date of notification from the Department that monies are owed to the Department the difference between the provider participation fee amount actually paid and the provider participation fee amount which should have been paid.

B) If the recalculation indicates that the hospital paid a total provider participation fee during the twelve-month period which exceeded that which the hospital should have been required to pay based upon actual rate year utilization, actual annualized spending or actual gross receipts during the period to which the provider participation fee relates, the Department shall refund within 60 days of the date of notification from the Department that monies are due to the hospital the difference between the amount the hospital actually paid and the amount of the provider participation fee the hospital should have paid.

3) In no event shall the payments to a hospital, less the fees paid by the hospital under subsections (b) and (c) above, equal less than the payments from the hospital's State fiscal year 1991 weighted average payment rates reduced by 5 percent.

4) Amounts recovered from a hospital shall be credited to the Fund. A hospital is entitled to recover amounts paid to the Department and to receive refunds and payments from the Department under this Section only to the extent that monies are available in the Fund.

5) Upon notification of the results of the Department's annual audit/reconciliation, each hospital shall have the right to reconsideration of the results of such annual audit/ reconciliation. Such requests for reconsideration must be received in writing within thirty (30) calendar days of the date of the Department's notification of the fee due. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of the receipt of all required review material. If the hospital fails to request a reconsideration pursuant to this subsection, the Department's determination shall be final.

m) Applicability.
The requirements of this Section shall apply only as long as federal funds under Title XIX of the Social Security Act are available to match the fees collected and disbursed under this Section and only as long as reimbursable expenditures are matched at the Federal Medicaid percentage of at least 50 percent. Whenever the Department is informed that federal funds are not available for these purposes, or shall be available at a lower percentage, this Section shall no longer apply, and the Department shall promptly refund to each hospital the amount of money currently in the Fund that has been paid by the hospital, plus any investment earnings on that amount.

n) Definitions.

As used in this Section, unless the context requires otherwise:

1) "Actual annualized Medicaid spending" means the actual expenditures made by the Department for services provided during the State fiscal year in which the fee described in subsection (b)(1) of this Section is due and which have been paid within nine (9) months from the end of such State fiscal year (for example, services provided in fiscal year 1992 and paid no later than March 31, 1993 for fees imposed in State fiscal year 1992; services provided in fiscal year 1993 and paid no later than March 31, 1994 for fees imposed in State fiscal year 1993; etc.). Such expenditures shall not include disproportionate share payments, targeted access payments, critical care access payments or uncompensated care payments.

2) "Actual gross receipts" means the gross receipts, as determined and reported by the Department, for services provided during the previous fiscal year which have been paid within nine (9) months from the end of such previous State fiscal year (for example, services provided in fiscal year 1991 and paid no later than March 31, 1992, for fees described in subsection (b)(2) of this Section which are imposed in State fiscal year 1992; services provided in fiscal year 1992 and paid no later than March 31, 1993, for fees described in subsection (b)(2) of this Section which are imposed in State fiscal 1993; etc.).

3) "Actual rate year utilization" means the actual utilization of services provided during the State fiscal year in which the fee described in subsection (b)(1) of this Section is due and which have been paid within nine (9) months from the end of such State fiscal year (for example, services provided in fiscal year 1992 and paid no later than March 31, 1993 for fees imposed in State fiscal year 1992; services provided in fiscal year 1993 and paid no later than March 31, 1994 for fees imposed in State fiscal year 1993; etc.).

4) "Anticipated annualized Medicaid spending" means the Department's estimate of expenditures which will be made to the hospital for services provided in the State fiscal year in which the fee described in subsection (b)(1) of this Section is due (for example, fiscal year 1992 for fees imposed in State fiscal year 1992, fiscal year 1993 for fees imposed in State fiscal year 1993, etc.). Such expenditures shall not include disproportionate share payments, targeted access payments, critical care access payments or uncompensated care payments.

5) "Estimated rate year utilization" means the hospital's projected utilization for the State fiscal year in which the fee described in subsection (b)(1) of this Section is due (for example, fiscal year 1992 for fees imposed in State fiscal year 1992, fiscal year 1993 for fees imposed in State fiscal year 1993, etc.).

6) "Fund" means the Hospital Services Trust Fund.

7) "Gross Receipts" means all payments for medical services delivered under Title XIX of the Social Security Act and Articles V, VI and VII of the Public Aid Code and shall mean any and all payments made by the Department, or a Division thereof, to a Medical Assistance Program provider certified to participate in the Illinois Medical Assistance Program, for services rendered eligible for Medical Assistance under Articles V, VI and VII of the Public Aid Code, State regulations and the

federal Medicaid Program as defined in Title XIX of the Social Security Act and federal regulations.

8) "Hospital" means any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located, and is required to submit cost reports to the Department under 89 Ill. Adm. Code 148, but shall not include the University of Illinois Hospital Act or a county hospital in a county of over 3 million population.

9) "Total Medicaid Base Year Spending" means the hospital's State fiscal year 1991 weighted average payment rates, excluding payments made under 89 Ill. Adm. Code 148.120 and Section 5-5.02 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-5.02), reduced by 5 percent and multiplied by the hospital's estimated rate year utilization.

10) "Weighted Average Payment Rate" means the hospital's payment rates for specific services, divided by the hospital's utilization for those specific services, plus any disproportionate share and outlier adjustments and less any third party liability payments.

o) Fee Assurances

1) Notwithstanding any provision of any rule of the Illinois Department of Public Aid, if either of the following events occurs:

A) Federal funds under Title XIX of the Social Security Act are no longer available to match the fees collected and disbursed under Section 14-3 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-3) or the State's expenditures are matched at a Federal Medicaid percentage of less than 50%; or

B) The State Plan amendment, in substantially the form submitted to the Health Care Financing Administration ("HCFA") prior to October 1, 1991, implementing the disbursement methodology set forth in Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8) is disapproved by HCFA.

2) Then the Department shall:

A) Make payments to hospitals in an amount commensurate with the payment rates that would have been paid pursuant to Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8), the proposed State Plan amendment, and rules implementing such Section for services provided to Medicaid recipients during the period for which fees have been collected under Section 14-3 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-3) (fees due on the first business day of one quarter are considered collected for the previous quarter pursuant to subsection (c)(2) above); or

B) If the Department cannot make payments at the level described in subsection (o)(2)(A) above, refund to the hospital the hospital's fee, or portion thereof, which has not been recouped by the hospital through the payment rates as described in subsection (o)(2)(A) above. The difference between the actual payments made to the hospital and the payments that would have been made to the hospital based on the hospital's total Medicaid base year spending shall be considered the amount of the fee recouped by the hospital.

(Source: Amended at 17 Ill. Reg. 3421, effective February 19, 1993)

Section 140.96 General Requirements (Recodified)

(Source: Recodified to 89 Ill. Adm. Code l48.30 at 13 Ill. Reg. 9572)

Section 140.97 Special Requirements (Recodified)

(Source: Recodified to 89 Ill. Adm. Code l48.40 at 13 Ill. Reg. 9572)

Section 140.98 Covered Hospital Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code l48.50 at 13 Ill. Reg. 9572)

Section 140.99 Hospital Services Not Covered (Recodified)

(Source: Recodified to 89 Ill. Adm. Code l48.60 at 13 Ill. Reg. 9572)

Section 140.100 Limitation On Hospital Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.70 at 13 Ill. Reg. 9572)

Section 140.101 Transplants (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.80 at 13 Ill. Reg. 9572)

Section 140.102 Heart Transplants (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.90 at 13 Ill. Reg. 9572)

Section 140.103 Liver Transplants (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.100 at 13 Ill. Reg. 9572)

Section 140.104 Bone Marrow Transplants (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.110 at 13 Ill. Reg. 9572)

Section 140.110 Disproportionate Share Hospital Adjustments (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118)

Section 140.116 Payment for Inpatient Services for GA (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.130 at 13 Ill. Reg. 9572)

Section 140.117 Hospital Outpatient and Clinic Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.140 at 13 Ill. Reg. 9572)

Section 140.200 Payment for Hospital Services During Fiscal Year l982 (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.150 at 13 Ill. Reg. 9572)

Section 140.201 Payment for Hospital Services After June 30, 1982 (Repealed)

(Source: Repealed at 9 Ill. Reg. 9564, effective June 5, 1985)

Section 140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.160 at 13 Ill. Reg. 9572)

Section 140.203 Limits on Length of Stay by Diagnosis (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.170 at 13 Ill. Reg. 9572)

Section 140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.180 at 13 Ill. Reg. 9572)

Section 140.350 Copayments (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.190 at 13 Ill. Reg. 9572)

Section 140.360 Payment Methodology (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.200 at 13 Ill. Reg. 9572)

Section 140.361 Non-Participating Hospitals (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.210 at 13 Ill. Reg. 9572)

Section 140.362 Pre July 1, 1989 Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.220 at 13 Ill. Reg. 9572)

Section 140.363 Post June 30, 1989 Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.230 at 13 Ill. Reg. 9572)

Section 140.364 Prepayment Review (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.240 at 13 Ill. Reg. 9572)

Section 140.365 Base Year Costs (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.250 at 13 Ill. Reg. 9572)

Section 140.366 Restructuring Adjustment (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.260 at 13 Ill. Reg. 9572)

Section 140.367 Inflation Adjustment (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.270 at 13 Ill. Reg. 9572)

Section 140.368 Volume Adjustment (Repealed)

(Source: Peremptory repealer at 8 Ill. Reg. 18151, effective September 18, 1984)

Section 140.369 Groupings (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.280 at 13 Ill. Reg. 9572)

Section 140.370 Rate Calculation (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.290 at 13 Ill. Reg. 9572)

Section 140.371 Payment (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.300 at 13 Ill. Reg. 9572)

Section 140.372 Review Procedure (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.310 at 13 Ill. Reg. 9572)

Section 140.373 Utilization (Repealed)

(Source: Repealed at 13 Ill. Reg. 3351, effective March 6, 1989)

Section 140.374 Alternatives (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.320 at 13 Ill. Reg. 9572)

Section 140.375 Exemptions (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.330 at 13 Ill. Reg. 9572)

Section 140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)

(Source: Repealed at 13 Ill. Reg. 3351, effective March 6, 1989)

Section 140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.340 at 13 Ill. Reg. 9572)

Section 140.391 Definitions (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.350 at 13 Ill. Reg. 9572)

Section 140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.360 at 13 Ill. Reg. 9572)

Section 140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.370 at 13 Ill. Reg. 9572)

Section 140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.380 at 13 Ill. Reg. 9572)

Section 140.398 Hearings (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 148.390 at 13 Ill. Reg. 9572)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.400 Payment to Practitioners

a) This Section applies to physicians, dentists, Advanced Practice Nurses (APN) (see Section 140.435), optometrists, podiatrists and chiropractors.

1) Practitioners are required to bill the Medical Assistance Program at the same rate they charge patients paying their own bills and patients covered by other third party payers.

2) A practitioner may bill only for services he or she personally provides or which are provided under his or her direct supervision in his or her office by his or her staff. An APN, as described in Section 140.435, may bill only for the services personally provided by the individual APN.

3) Payment will be made only in the practitioner's name or a Department approved alternate payee.

4) Payments will be made according to a schedule of statewide pricing screens established by the Department. Covered services provided by qualifying providers under the Maternal and Child Health Program will be reimbursed at enhanced rates as described in subsection (b) of this Section. The pricing screens are to be established based on consideration of the market value of the service. In considering the market value, the Department will examine the costs of operations and material. Input from advisory groups designated by statute, generally recognized provider interest groups and the general public will be taken into consideration in determining the allocation of available funds to rate adjustments. Increases in rates are contingent upon funds appropriated by the General Assembly. Reductions or increases may be affected by changes in the market place or changes in funding available for the Medical Assistance Program. Screens will be related to the average statewide charge. The upper limit for services shall not exceed the lowest Medicare charge levels.

b) Practitioners who meet the qualifications for and enter into a Primary Care Provider Agreement for participation in the Maternal and Child Health Program, as described in Subpart G, will receive enhanced reimbursement in accordance with Section 140.930(a)(1).

c) The Department will distribute (initially and upon revision of the amounts) to practitioners the maximum allowable amounts for the most commonly billed procedures codes. Interested individuals may request a copy of the maximum

allowable amounts from the Department by directing the request to the Bureau of Comprehensive Health Services, Prescott E. Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763-0001. In addition, a participating individual practitioner may request the maximum allowable amounts for less commonly billed specific procedures that relate to the individual's practice. This request must be in writing and identify specific procedure codes and associated descriptions.

d) Supplemental payments to universities for certain practitioner services

1) Supplemental payments are available for services that are provided by practitioners who are employed by an Illinois public university and are services eligible under Titles XIX and XXI of the Social Security Act.

A) For dates of service on or after April 1, 2009, supplemental payment will be made on a quarterly basis as described in subsection (d) of this Section.

B) Supplemental payments under this subsection (d) are subject to federal approval.

C) Supplemental payments shall be funded through cooperative agreements between the Department and the State university.

2) Definitions

A) "Average Commercial Fee Schedule" means the average commercial fee schedule paid to the university for practitioner services, including patient share amounts, for each CPT code. This average shall be based on the participating university's payments from the five largest private insurance carriers for CPT services.

B) "Base Period Average Commercial Payment Ceiling" means the following computation:

i) Multiplying the Average Commercial Fee Schedule by the number of paid claims provided in the base period and paid to the university for clients eligible under Titles XIX and XXI of the Social Security Act.

ii) Summing the products for all procedure codes as described in subsection (d)(2)(B)(i) of this Section.

C) "Base Period Medicare Equivalent Payment Ceiling" means the

following computation:

i) Multiplying the Medicare allowed rate as reported in the April release of the Resources Based Relative Value Scale (RBRVS), by the number of paid claims provided in the based period and paid to the university for clients eligible under Title XIX or XXI of the Social Security Act.

ii) Summing the products for all procedure codes as described in subsection (d)(2)(B)(i) of this Section.

D) "Base Period Medicare Equivalent of the Average Commercial Rate" means the Base Period Average Commercial Payment Ceiling divided by the Base Period Medicare Equivalent Payment Ceiling.

3) The supplemental payments shall be determined as follows:

A) The Medicare Equivalent of the Average Commercial Rate for a practitioner service will be determined by multiplying the Base Period Medicare Equivalent of the Average Commercial Rate by the Medicare payment at the non-facility rate per CPT code for the current period.

B) The rates determined in subsection (d)(3)(A) of this Section are multiplied by the number of claims for the current period, as reported through the Medicaid Management Information System, to determine the current period supplemental payment ceiling.

C) The supplemental payment to the university shall equal the current period payment ceiling at the Medicare Equivalent of the Average Commercial Rate less all payments otherwise made by the Department for the same services for procedure codes rendered in the current period and paid to the university. These supplemental payments shall be based on all available payments and adjustments on file with the Department at the time the payment amount is determined.

4) Periodic Updates to the Base Period Medicare Equivalent of the Average Commercial Rate: The Department shall update this ratio at least every three years.

(Source: Amended at 34 Ill. Reg. 5215, effective March 25, 2010)

Section 140.402 Copayments for Noninstitutional Medical Services

a) Effective July 1, 2003, each recipient, with the exception of those classes of recipients identified in subsection (d) of this Section, may be required to pay the following specified copayment for noninstitutional medical services:

1) Each office visit to a chiropractor, podiatrist, optometrist, or a physician licensed to practice medicine in all its branches billed to the Department, with the exception of those office visits for services identified in subsection (e) of this Section, may require a copayment of $2.00.

2) Each brand name legend drug billed to the Department, with the exception of drugs identified in subsection (e) of this Section, may require a copayment of $3.00.

b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the respective amount of the required copayment.

c) No provider of services listed in subsection (a) of this Section may deny service to an individual who is eligible for service on account of the individual's inability to pay the cost of a copayment.

d) The following individuals receiving medical assistance are exempt from the copayment requirement set forth in subsection (a) of this Section:

1) Pregnant women, including a postpartum period of 60 days.

2) Children under 19 years of age.

3) All noninstitutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections.

4) Hospice patients.

5) Individuals residing in hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

6) Residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their

residential care program. For the purpose of this subsection (d)(6), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).

e) The following medical services are exempt from any copayments:

1) Renal dialysis treatment.

2) Radiation therapy.

3) Cancer chemotherapy.

4) Use of insulin.

5) Services for which Medicare is the primary payer.

6) Over-the-counter drugs.

7) Emergency services as defined at 42 CFR 447.53(b)(4).

8) Any pharmacy compounded drugs.

9) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.

10) Family planning services.

11) Other therapeutic drug classes as specified by the Department.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.403 Telehealth Services

a) Definitions

1) "Asynchronous Store and Forward Technology" means the transmission of a patient's medical information from an originating site to the provider at the distant site. The provider at the distant site can review the medical case without the patient being present. An asynchronous telecommunication system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs visualized by a telecommunication system must be specific to the patient' s medical condition and adequate for furnishing or confirming a diagnosis and/or treatment plan. Dermatological photographs (for example, a photograph of a skin lesion) may be considered to meet the requirement of a single media format under this provision.

2) "Distant Site" means the location at which the provider rendering the service is located.

3) "Encounter Clinic" means a Federally Qualified Health Center, Rural Health Clinic or Encounter Rate Clinic, as defined in 89 Ill. Adm. Code 140.461.

4) "Facility Fee" means the reimbursement made to the following originating sites for the telehealth service: physician's office, podiatrist's office, local health departments, community mental health centers, licensed hospital outpatient departments as defined in 89 Ill. Adm. Code 148.25(d) and substance abuse treatment centers licensed by the Department of Human Services-Division of Alcoholism and Substance Abuse (DASA).

5) "Interactive Telecommunication System" means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site provider. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunication system.

6) "Originating Site" means the location at which the participant receiving the service is located.

7) "Telecommunication System" means an asynchronous store and forward technology and/or an interactive telecommunication system that is used to

transmit data between the originating and distant sites.

8) "Telehealth" means services provided via a telecommunication system.

9) "Telemedicine" means the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location.

10) "Telepsychiatry" means the use of a telecommunication system to provide psychiatric services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location.

b) Requirements for Telehealth Services

1) Telemedicine

A) A physician or other licensed health care professional must be present at all times with the patient at the originating site.

B) The distant site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by the State of Illinois or by the state where the patient is located.

C) The originating and distant site provider must not be terminated, suspended or barred from the Department's medical programs.

D) Medical data may be exchanged through a telecommunication system.

E) The interactive telecommunication system must, at a minimum, have the capability of allowing the consulting distant site provider 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.

2) Telepsychiatry

A) A physician, licensed health care professional or other licensed clinician, mental health professional (MHP), or qualified mental health professional (QMHP), as defined in 59 Ill. Adm. Code

132.25, must be present at all times with the patient at the originating site.

B) The distant site provider must be a physician licensed by the State of Illinois or by the state where the patient is located and must have completed an accredited general psychiatry residency program or an accredited child and adolescent psychiatry residency program.

C) The originating and distant site provider must not be terminated, suspended or barred from the Department's medical programs.

D) The distant site provider must personally render the telepsychiatry service.

E) Telepsychiatry services must be rendered using an interactive telecommunication system.

F) Group psychotherapy is not a covered telepsychiatry service.

c) Reimbursement for Telehealth Services

1) Originating Site Reimbursement

A) A facility fee shall be paid to providers as defined in subsection (a)(4) of this Section.

B) Local education agencies may submit telehealth services as a certified expenditure.

C) Providers who receive reimbursement for a patient's room and board are not eligible for reimbursement as an originating site.

D) Clinics reimbursed under the prospective payment system shall be eligible for a medical encounter as set forth in subsection (c)(3) of this Section.

2) Reimbursement for Rendering Provider at the Distant Site

A) Participating providers shall be reimbursed for the appropriate AMA Current Procedural Terminology (CPT) code for the telehealth service rendered.

B) Nonparticipating providers may be reimbursed by the originating site provider, but will not be eligible for reimbursement from the Department.

3) Clinic Reimbursement

A) An encounter clinic serving as the originating site shall be reimbursed for its medical encounter as defined in Section 140.462. The clinic is responsible for reimbursement to the distant site provider.

B) An encounter clinic serving as the distant site shall be reimbursed as follows:

i) If the originating site is another encounter clinic, the distant site encounter clinic shall receive no reimbursement from the Department. The originating site encounter clinic is responsible for reimbursement to the distant site encounter clinic; and

ii) If the originating site is not an encounter clinic, the distant site encounter clinic shall be reimbursed for its medical encounter. The originating site provider will receive a facility fee as defined in subsection (a)(4) of this Section.

d) Record Requirements for Telehealth Services

1) Medical records documenting the telehealth services provided must be maintained by the originating and distant sites and shall include, but not be limited to, the following:

A) The records required in Section 140.28;

B) The name and license number of the licensed health care professional or other licensed clinician present with the patient at the originating site;

C) The name and license number of the provider at the distant site and, if the service involves telepsychiatry, documentation that the physician has completed an approved general psychiatry residency program or an approved child and adolescent psychiatry residency program;

D) The locations of the originating and distant sites;

E) The date and the beginning and ending times of the telehealth service; and

F) The medical necessity for the telehealth service.

2) When the originating site is an encounter clinic, records from the distant site must also be maintained.

3) Appropriate steps must be taken by the originating and distant site staff to assure patient confidentiality, based on technical advances in compliance with all federal and state privacy and confidentiality laws.

4) The type of interactive telecommunication system utilized at the originating and distant sites shall be documented.

5) The billing records related to the use of the telecommunication system shall be maintained as provided in Section 140.28.

(Source: Added at 34 Ill. Reg. 903, effective January 29, 2010)

Section 140.405 SeniorCare Pharmaceutical Benefit (Repealed)

(Source: Repealed at 30 Ill. Reg. 10370, effective May 26, 2006)

Section 140.410 Physicians' Services

a) Payment shall be made only to physicians licensed to practice medicine in all its branches.

b) The restrictions and limitations which shall apply to physician participation include the following:

l) Interns are not eligible to participate;

2) Residents are eligible to participate where, by terms of their contract with the hospital, they are permitted to and do bill private patients and collect and retain the payments received for their services;

3) Hospital based specialists who are salaried, with the cost of their services included in the hospital reimbursement costs, are eligible to participate when their contractual arrangement with the hospital provides for them to make their own charges for professional services and they do, in fact, bill private patients and collect and retain payments made;

4) Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools are eligible to participate to the extent that they maintain a private practice and bill private patients and collect and retain payments made; and

5) Teaching physicians who provide direct patient care are eligible to participate if the salaries paid them by hospitals or other institutions do not include a component for treatment services.

Section 140.411 Covered Services By Physicians

The Department shall pay physicians for the provision of services not otherwise excluded which are:

a) Essential for the diagnosis and treatment of a disease or injury;

b) Included in the Physicians' Current Procedural Terminology (CPT) fourth edition, published by the American Medical Association; and

c) Provided by the physician or by a member of the physician's staff under the physician's direct supervision.

Section 140.412 Services Not Covered By Physicians

Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program. Additionally, the following services are specifically excluded from coverage and payment cannot be made by the Department for the provision of these services.

a) Experimental medical or surgical services.

b) Acupuncture
.

c) Investigational and research oriented procedures.

d) Artificial insemination.

e) Transsexual surgery.

f) Services prohibited by Illinois or Federal statute.

g) Services provided in Federal or State institutions.

h) Medical care provided by mail or telephone.

i) Unkept appointments.

j) Autopsy examinations.

k) Preparation of routine records, forms and reports.

l) Cosmetic procedures, medical or surgical, where projected results do not relieve a physical or functional handicap.

Section 140.413 Limitation on Physician Services

a) When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services:

1) Termination of pregnancy – only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother. All claims for reimbursement for abortions or induced miscarriages or premature births must be accompanied by the physician's written certification that the procedure is necessary for preservation of the life of the woman, or that the induced premature birth was to produce a live viable child and was necessary for the health of the mother or her unborn child.

2) Sterilization

A) Therapeutic sterilization – only when the procedure is either a necessary part of the treatment of an existing illness, or is medically indicated as an accompaniment of an operation on the female genitourinary tract. Mental incapacity does not constitute an illness or injury that would authorize this procedure.

B) Nontherapeutic sterilization – only for recipients age 21 or older and mentally competent. The physician must obtain the recipient's informed written consent in a language understandable to the recipient before performing the sterilization and must advise the recipient of the right to withdraw consent at any time prior to the operation. The operation shall be performed no sooner than 30 days and no later than 180 days following the date of the recipient's written informed consent, except in cases of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent was given.

3) Surgery for morbid obesity – the Department shall approve payment for this service only in those cases in which the physician determines that obesity is exogenous in nature, the recipient has had the benefit of other therapy with no success, endocrine disorders have been ruled out, and the body mass index (BMI) is 40 or higher, or 35 to 39.9 with serious medical complications. The medical record must contain the following documentation of medical necessity:

A) Documentation of review of systems (history and physical);

B) Client height, weight and BMI;

C) Listing of co-morbidities;

D) Patient weight loss attempts;

E) Current and complete psychiatric evaluation indicating the patient is an appropriate candidate for weight loss surgery; and

F) Documentation of nutritional counseling.

4) Psychiatric services

A) Treatment – when the services are provided by a physician who has been enrolled as an approved provider with the Department. Psychiatric treatment services are not covered services for recipients of General Assistance.

B) Consultation – only when necessary to determine the need for psychiatric care. Services provided subsequent to the initial consultation must comply with the requirements for treatment.

C) Group Psychotherapy – payment may be made for up to two group sessions per week, with a maximum of one session per day. The following conditions must be met for group psychotherapy:

i) documentation maintained in the patient's medical record must indicate the person participating in the group session has been diagnosed with a mental illness as defined in the International Classification of Diseases (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). The allowable diagnosis code ranges will be specified in the Handbook for Physicians; and

ii) beginning 1/1/10, the entire group psychotherapy service is directly performed by a 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; and

iii) the group size does not exceed 12 patients, regardless of payment source; and

iv) the minimum duration of a group session is 45 minutes; and

v) the group session is documented in the patient's medical record by the rendering physician, including the session's primary focus, level of patient participation, and begin and end times of each session; and

vi) the 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; and

vii) the group session is provided in accordance with a clear written description of goals, methods and referral criteria; and

viii) if the patient is a resident of a long term care facility, the provider of the group psychotherapy must maintain documentation in the patient's medical record demonstrating the coordination of services and the sharing with the long term care facility of information related to the patient's needs and the implementation and effectiveness of the patient's plan of care.

5) Services provided to a recipient in his or her home – only when the recipient is physically unable to go to the physician's office.

6) Services provided to recipients in group care facilities by a physician other than the attending physician – only for emergency services provided when the attending physician of record is not available or when the attending physician has made referral with the recipient's knowledge and permission.

7) Services provided to recipients in a group care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit in the facility) – only when occasioned by an emergency due to acute illness or unavailability of essential treatment facilities in the vicinity for short-term care pending transfer, or when there is no comparable facility in the area.

8) Maternity care – Payment shall be made for pre-natal and post-natal care only when the following conditions are met:

A) the physician, whether based in a hospital, clinic or individual practice, retains hospital delivery privileges, maintains a written referral arrangement with another physician who retains such privileges, or has been included in the Maternal and Child Health Program as a result of having entered into an appropriate Healthy Moms/Healthy Kids Program provider agreement;

B) the written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; and

C) maternal services are delivered in a manner consistent with the quality of care guidelines published by the American College of Obstetricians and Gynecologists in the current edition of the "Standards for Obstetric-Gynecologic Services" (1989 Edition), 409 12th Street, S.W., Washington, D.C. 20024-2188.

9) Physician services to children under age 21

A) Payment shall be made only when the physician meets one or more of the following conditions. The physician:

i) has admitting privileges at a hospital; or

ii) is certified or is eligible for certification in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties; or

iii) is employed by or affiliated with a Federally Qualified Health Center; or

iv) is a member of the National Health Service Corps; or

v) has been certified by the Secretary of the Department of Health and Human Services as qualified to provide physician services to a child under 21 years of age; or

vi) has current, formal consultation and referral arrangements with a pediatrician or family practitioner for the purposes of specialized treatment and admission to a hospital. The

written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; or

vii) has entered into a Maternal and Child Health provider agreement or has otherwise been transferred in from the Healthy Moms/Healthy Kids Program;

B) The physician shall certify to the Department the way in which he or she meets the above criteria; and

C) Services to children shall be delivered in a manner consistent with the standards of the American Academy of Pediatrics and rules published by the Illinois Department of Public Health (77 Ill. Adm. Code 630, Maternal and Child Health Services; 77 Ill. Adm. Code 665, Child Health Examination Code; 77 Ill. Adm. Code 675, Hearing Screening; 77 Ill. Adm. Code 685, Vision Screening).

10) Hysterectomy – only if the individual has been informed, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing and the individual has signed a written acknowledgment of receipt of the information. The Department will not pay for a hysterectomy that would not have been performed except for the purpose of rendering an individual permanently incapable of reproducing.

11) Selected surgical procedures, including:

A) Tonsillectomies or Adenoidectomies

B) Hemorrhoidectomies

C) Cholecystectomies

D) Disc Surgery/Spinal Fusion

E) Joint Cartilage Surgery/Meniscectomies

F) Excision of Varicose Veins

G) Submucous Resection/Rhinoplasty/Repair of Nasal System

H) Mastectomies for Non-Malignancies

I) Surgical procedures that generally may be performed in an outpatient setting (see Section 140.117) only if the Department authorizes payment. The Department will in some instances require that a second physician agree that the surgical procedure is medically necessary prior to approving payment for one of these procedures. The Department will require a second opinion when the attending physician has been notified by the Department that he or she will be required to obtain prior approval for payment for the surgeries listed. (See Sections 140.40 through 140.42 for prior approval requirements.) The Department will select physicians for this requirement based on the recommendation of a peer review committee that has reviewed the utilization pattern of the physician.

12) Mammography screening

A) Covered only when ordered by a physician for screening by low-dose mammography for the presence of occult breast cancer under the following guidelines:

i) a baseline mammogram for women 35 through 39 years of age; and

ii) a mammogram once per year for women 40 years of age or older.

B) As used in this subsection (a)(12), "low-dose mammography" means the x-ray examination of the breast using equipment specifically designated for mammography that will meet appropriate radiological standards.

13) Pap tests and prostate-specific antigen tests – coverage is provided for the following:

A) An annual cervical smear or Pap smear test for women.

B) An annual digital rectal examination and a prostate-specific antigen test, upon the recommendation of a physician licensed to practice medicine in all its branches, for:

i) asymptomatic men age 50 and over;

ii) African-American men age 40 and over; and

iii) men age 40 and over with a family history of prostate cancer.

b) In cases in which a physical examination by a second physician is needed, the Department will notify the recipient and designate a physician to perform the examination. Physicians will be subject to this requirement for six months, after which a request can be submitted to the peer review committee to consider removal of the prior approval requirement.

(Source: Amended at 33 Ill. Reg. 12227, effective October 1, 2009)

Section 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescibers

For the purpose of this Section, "prescriber" shall mean any person who, within the scope of his or her professional licensing requirements, may prescribe or dispense drugs.

a) Prescriptions

1) A prescriber may prescribe any pharmacy item, not otherwise excluded, that, in the prescriber's professional judgment, is essential for the diagnosis or accepted treatment of a recipient's present symptoms. The Department may require prior approval of any drug except as outlined in Section 140.442(a)(9).

2) A prescriber shall:

A) Use a tamper-resistant prescription form, as defined at Section 140.443(b)(2), for non-electronic prescriptions. Non-electronic prescriptions are defined at Section 140.443(b)(1). In addition, the prescriber shall ensure the prescription form is compliant with Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23); and

B) Enter on the form all data elements required under Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23), as well as one of the following data elements identifying the prescriber:

i) Drug Enforcement Administration (DEA) Number; or

ii) National Provider Indentifier (NPI); or

iii) Medical Assistance Program Provider Number; or

iv) Illinois State License Number.

3) The prescriber shall not charge for writing a prescription.

4) Items that shall not be prescribed are listed in Section 140.441.

b) Dispensed Items

1) A participating prescriber may dispense pharmacy items subject to the Department's coverage policies. The prescriber shall not charge for any

samples dispensed or anesthesia agents administered for office surgical procedures.

2) The Department shall pay for items dispensed in an emergency or when not readily available from a pharmacy at the rate of the cost to the prescriber for the item, plus 20% of the cost when itemized. The Department will pay a maximum of $1.00 for unitemized items.

(Source: Amended at 33 Ill. Reg. 9048, effective June 15, 2009)

Section 140.416 Optometric Services and Materials

a) Payment for optometric services and materials shall be made to physicians, optometrists, opticians and optical companies.

b) Payment shall be made for the following optometric services and materials:

1) An eye examination by a physician or an optometrist for the purpose of determining the condition of the eye including the refractive state.

2) Frame repairs, contact lenses, artificial eyes and low vision devices provided by physicians, optometrists, opticians and optical companies.

3) Dispensing of optical materials.

4) Lenses, frame parts and frames provided by the Department of Corrections (DOC) laboratory.

c) Optometric services and materials for which payment shall not be made include:

1) Services which are not provided to address a recipient's particular visual problems or complaints.

2) Lenses, frames and frame parts obtained from a source other than the DOC laboratory.

3) Trifocals.

4) Tinted lenses.

5) Provider's transportation costs.

d) Payment for services and materials shall be at the lesser of the provider's usual and customary charge or the maximums established by the Department pursuant to Section 140.400.

(Source: Amended at 25 Ill. Reg. 6665, effective May 11, 2001)

Section 140.417 Limitations on Optometric Services

Payment for the following optometric services and materials shall be made subject to the following limitations:

a) Payment shall be made for single vision lenses only when the following conditions are met:

l) The power is at least O.75 diopters in either the sphere or cylinder component; or

2) The difference between the old and new prescription is at least O.75 diopters in either the sphere or cylinder component.

b) Payment shall be made for bifocal lenses only when the following conditions are met:

1) For first bifocals, the power of the bifocal addition is at least 1.00 diopter.

2) For a change in bifocal lenses, the power of the bifocal addition is changed by at least 0.50 diopters or the distance power represents a change of at least 0.75 diopters.

c) Payment shall be made for more than one examination per year only when the vendor documents the need for the additional examination.

d) Payment shall be made for more than one pair of eyeglasses or set of lenses per year only when the physician or optometrist documents:

1) that:

A) the most recent pair of eyeglasses or set of lenses was lost or destroyed for reasons beyond the control of the recipient; or

B) there is a change in the prescription that meets the requirements in subsection (a)(2) or (b)(2) of this Section; and

2) that the additional pair is medically necessary.

e) Payment for optometric materials dispensed by a supplier other than a physician or optometrist, except for replacement and repair items, shall be made only when they are prescribed by a licensed physician or optometrist.

f) Prior approval pursuant to Section 140.40 is required for the services and materials described in this subsection (f). Approval shall be given when, in the judgment of a Department consultant, the requested item or service is appropriate.

l) Contact lenses and related contact lens services;

2) A third pair of eyeglasses in one year for adults 21 years of age or older;

3) Custom made artificial eyes;

4) Low vision devices; and

5) Any item or service not specifically included in the schedule of procedures for optical services and supplies.

(Source: Amended at 25 Ill. Reg. 6665, effective May 11, 2001)

Section 140.418 Department of Corrections Laboratory

All lenses, frames and frame parts shall be obtained from the Department of Corrections (DOC) laboratory. DOC shall not engage in "office" services, such as examinations or dispensing of eyeglasses to recipients, but shall be the State's laboratory for fabrication of eyeglasses. Individual optical suppliers shall continue to provide examinations, frame repairs, contact lenses, artificial eyes and low vision devices, as well as dispensing of eyeglasses obtained from the DOC laboratory. Payment for fabrication of eyeglasses shall be made by the Department of Public Aid directly to the Department of Corrections.

(Source: Amended at 25 Ill. Reg. 6665, effective May 11, 2001)

Section 140.420 Dental Services

a) Payment for dental services shall be made only to enrolled licensed dentists. Payment for comprehensive orthodontic care shall be made only to a dentist licensed for provision of such services.

b) Except for the "services not covered" specified in subsection (c) of this Section, payment shall be made for dental services that are:

1) Necessary to relieve pain or infection, preserve teeth, or restore adequate dental function;

2) Diagnostic, preventive, or restorative services, endodontics, prosthodontics, orthodontics or oral surgery included in the Department's Schedule of Dental Procedures (see Table D of this Part); and

3) Performed by the dentist or under the direct supervision of the dentist.

c) Services for which payment shall not be made include:

1) Routine or periodic examinations other than clinical oral examinations (see Table D(a)(1));

2) Experimental dental care;

3) Procedures performed only for cosmetic reasons;

4) Dental prophylaxis for individuals 21 years and older;

5) Topical fluoride treatment and sealants for individuals age 21 years and older;

6) Space maintainers for individuals age 21 years and older;

7) Acrylic crown;

8) Prefabricated stainless steel crown for primary tooth for individuals age 21 years and older;

9) Therapeutic pulpotomy for individuals age 21years and older;

10) Bicuspid and molar root canals, apexification, and apicoectomy procedures for anterior teeth, bicuspids, and permanent first molars for individuals age 21 years and older;

11) Periodontics for individuals age 21 years and older;

12) Partial dentures for adults age 21 years and older;

13) All dentures placed prior to five year expiration (see Section 140.421(c));

14) Bridgework for individuals age 21 years and older;

15) Surgical exposure to aid eruption for individuals age 21 years and older;

16) Alveoloplasty for individuals age 21 years and older;

17) Frenulectomy for individuals age 21 years and older; and

18) Orthodontics for individuals age 21 years and older.

(Source: Amended at 27 Ill. Reg. 14799, effective September 5, 2003)

Section 140.421 Limitations on Dental Services

a) Prior approval is required for:

1) Space maintainers;

2) Crowns;

3) Endodontic services with the exception of therapeutic pulpotomy;

4) Periodontal services;

5) Dentures, partial dentures and denture relines;

6) Maxillofacial prosthetics;

7) Bridgework;

8) Removal of impacted teeth;

9) Surgical removal of residual roots;

10) Surgical exposure to aid eruption;

11) Alveoloplasty;

12) Incision and drainage of abscess;

13) Frenulectomy;

14) Orthodontics. Medically necessary orthodontic treatment is approved for children. The Department's consultant shall make the initial decision whether or not to approve orthodontic treatment. Medically necessary orthodontic treatment is defined as:

A) treatment necessary to correct a condition which scores 42 points or more on the Salzmann Index, or

B) treatment necessary to correct a condition that constitutes a handicapping malocclusion. (A malocclusion is handicapping if there is an impairment of or a hazard to the ability to eat, chew, speak or breathe that is related to the malocclusion.);

15) Analgesia (nitrous oxide);

16) Therapeutic drug injection;

17) Other drugs and medicaments;

18) Unspecified miscellaneous adjunctive general services procedure or service;

19) Dental services not included in the Department's Schedule of Dental Procedures (see Table D of this Part).

b) The dentist may request post-approval when a dental procedure requiring prior approval is provided on an emergency basis. Approval of the procedures shall be given if, in the judgment of a consulting dentist of the Department or a consulting dental service, the procedure is necessary to prevent dental disease or to restore and maintain adequate dental function to assure good bodily health and the well-being of the patient.

c) Payment for complete and partial dentures is limited to one set every five years if necessary to replace lost, broken or unusable dentures; payment for a bridge is limited to once in five years. Bridgework will be reimbursed only if there has not been placement of a partial denture within the prior five years.

d) Root canals, apexification, and apicoectomy procedures are covered for children for anterior teeth, bicuspids, and permanent first molars. Root canals are covered for adults only for anterior teeth.

e) Panoramic x-rays are covered only once every three years.

(Source: Amended at 27 Ill. Reg. 14799, effective September 5, 2003)

Section 140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items – Dentists (Repealed)

(Source: Repealed at 33 Ill. Reg. 9048, effective June 15, 2009)

Section 140.425 Podiatry Services

a) Payment for podiatry services shall be made only to licensed podiatrists.

b) Payment shall be made for those podiatric services that are:

1) Essential for the diagnosis and treatment of conditions of the feet.

2) Listed in the Current Procedural Terminology (CPT) for podiatric office visits, diagnostic radiology, pathology, or orthomechanical procedures included in the Department's schedule of podiatric services.

3) Performed by the podiatrist or under the direct supervision of the podiatrist.

4) Routine foot care services (trimming of nails, treatment of calluses, corns, and similar services) when a participant is under active treatment for diabetes mellitus or has a systemic condition that has resulted in severe circulatory impairment or an area of desensitization in the legs or feet and a routine type of foot care is required. These services may not be provided at less than 60 day intervals.

c) Payment shall not be made for the following services:

1) Making a referral, obtaining a specimen, handling a specimen for analysis, or ordering a laboratory test,

2) Visits and services provided to recipients eligible for Medicare benefits if the services are determined not medically necessary by Medicare,

3) Services provided to recipients in group care facilities by a podiatrist who derives direct or indirect profit from total or partial ownership of the facility,

4) Routine foot care, except as described in subsection (b)(4) of this Section,

5) Screening for foot problems,

6) Provider transportation costs,

7) X-rays, and laboratory procedures performed at a location other than the podiatrist's own office,

8) X-rays, laboratory work or similar services not specifically required by the

condition for which the recipient is being treated,

9) Routine post-operative visits.

(Source: Amended at 33 Ill. Reg. 16573, effective November 16, 2009)

Section 140.426 Limitations on Podiatry Services

a) Payment for an initial visit shall be made only one time for an individual patient to determine whether foot care is required and covered by the Department's program. In partnership or group practices, it is allowed only one time collectively for all podiatrists in the group.

b) Payment for blood work by the "dipstick" method shall be made only when a colorimetric instrument is used for evaluation of the results.

c) Payment for orthomechanics, multiple surgical procedures or surgical procedures within a six (6) month period following original surgery shall be made only when the podiatrist obtains prior approval from the Department.

Section 140.427 Requirements for Prescriptions and Dispensing of Pharmacy Items − Podiatry (Repealed)

(Source: Repealed at 33 Ill. Reg. 9048, effective June 15, 2009)

Section 140.428 Chiropractic Services

a) Payment shall be made only to chiropractors.

b) Payment shall be made for only one chiropractic service: manual manipulation of the spine to correct a subluxation of the spine which has resulted in a neuromusculoskeletal condition for which such manipulation is an appropriate treatment

(Source: Amended at 14 Ill. Reg. 4543, effective March 12, 1990)

Section 140.429 Limitations on Chiropractic Services (Repealed)

(Source: Repealed at 14 Ill. Reg. 4543, effective March 12, 1990)

Section 140.430 Independent Clinical Laboratory Services

a) Payment for clinical laboratory services may be made to a laboratory that is independent both of a physician's practice and of a hospital.

b) In order to participate in the Medical Assistance Program, the independent laboratory must be licensed and certified for participation in the Medicare program. Approval for participation in the program is not transferrable and shall only apply to the location and the owner specified on the laboratory's enrollment application.

c) Payment shall be made for only those laboratory services that have been ordered in writing by the referring practitioner as being essential to diagnosis and treatment. The practitioner must include the diagnosis or condition on the written request.

(Source: Amended at 23 Ill. Reg. 7122, effective June 1, 1999)

Section 140.431 Services Not Covered by Independent Clinical Laboratories

a) Payment shall not be made for any service that a clinical laboratory is not Medicare certified to provide.

b) Payment shall not be made for the following clinical laboratory services:

1) Any test which has not been performed on the laboratory's premises, by the laboratory's staff, using the laboratory's equipment and supplies.

2) The collection and handling of specimens obtained for referral to another laboratory.

3) Laboratory tests that are available without charge from other sources, including the Illinois Department of Public Health. The Department will pay, however, for throat cultures when the referring physician determines use of a Department of Public Health laboratory would result in delay in diagnosis and treatment.

4) Sensitivity studies when a culture shows no growth or when a growth is identified as beta hemolytic streptococcus.

5) Tests ordered for Healthy Kids screening purposes.

6) Tests and study of specimens referred as a result of an autopsy examination.

7) Laboratory services provided to recipients eligible for Medicare Part B benefits when the Medicare intermediary determines that the services are not medically necessary.

8) Laboratory services when not specifically required by the condition for which the recipient is being treated.

(Source: Amended at 23 Ill. Reg. 7122, effective June 1, 1999)

Section 140.432 Limitations on Independent Clinical Laboratory Services

The Department shall pay for the following services only when they are provided in accordance with the limitations specified:

a) Vitamin B-l2 testing – only in those cases in which a completed blood count has shown a macrocytic hormochromic anemia and a high lactic dehydrogenase.

b) Home Visits – only when the recipient's attending physician indicates on the order that the recipient is physically unable to travel to the laboratory and if it is the custom of the laboratory to charge the general public a home visit fee in addition to the fee for the laboratory service.

c) Routine, multi-channel (battery) tests – only those instances where the tests performed are consistent with the recipient's diagnosis and/or conditions.

(Source: Amended at 23 Ill. Reg. 7122, effective June 1, 1999)

Section 140.433 Payment for Clinical Laboratory Services

a) Payment for allowable laboratory services includes payment for collection and handling of specimens by laboratory personnel, use of laboratory equipment and supplies, and the written report of test results to the referring practitioner.

b) Payment for allowable laboratory services provided to recipients who are not eligible for Medicare Part B benefits is based on the laboratory's usual and customary charges within the limitations established by the Department (see Section 140.400).

c) For recipients eligible for Medicare Part B Coverage, payment is made on deductible and coinsurance amounts up to the limitations established by the Department for the service.

d) Payment for three or more blood chemistries performed on the same specimen is made on a basis related to the use of automated equipment.

e) When the laboratory performs profile testing, it must bill the Department by profile. The Department considers two or more thyroid tests performed on the same specimen to be profile testing.

(Source: Amended at 23 Ill. Reg. 7122, effective June 1, 1999)

Section 140.434 Record Requirements for Independent Clinical Laboratories

a) In addition to the record requirements specified in Section 140.28, independent clinical laboratories must comply with the administrative rules of the Illinois Department of Public Health governing the maintenance of medical records that are found at 77 Ill. Adm. Code 450, Illinois Clinical Laboratories Code.

b) The basic records that must be retained include, but are not limited to:

1) All original orders from practitioners for laboratory services for Public Aid recipients.

2) All copies of reports to referring practitioners.

3) Records that verify usual and customary charges to the general public.

c) In the absence of proper and complete records, no payment will be made and payments previously made for services that are not documented will be recouped.

(Source: Amended at 23 Ill. Reg. 7122, effective June 1, 1999)

Section 140.435 Advanced Practice Nurse Services

a) For purposes of enrollment in the Medical Assistance Program, an advanced practice nurse (APN) means a person who is licensed as a registered professional nurse, holds a valid license in the state of practice and is legally authorized under state law or rule to practice as an advanced practice nurse, so long as that practice is not in conflict with the Nurse Practice Act [225 ILCS 65], the Medical Practice Act of 1987 [225 ILCS 60] and implementing rules (68 Ill. Adm. Code 1305). Categories of APNs include:

1) Certified Registered Nurse Anesthetist (CRNA);

2) Certified Nurse Midwife (CNM);

3) Certified Nurse Practitioner (CNP); and

4) Clinical Nurse Specialist (CNS).

b) An APN must have and maintain a current collaborative or written practice agreement with a collaborating physician or practitioner under whom the APN will be practicing, as set forth in the Nurse Practice Act.

c) Depending on the site of care, CRNAs may or may not be required to possess a written collaborative or written practice agreement as set forth in the Nurse Practice Act. CRNAs may work in a hospital, a physician's, dentist's or podiatrist's office, or an Ambulatory Surgical Treatment Center.

d) The agreement or agreements required under subsections (b) and (c) shall comply with all requirements as described in the Nurse Practice Act and 68 Ill. Adm. Code 1305. Agreements required under the Act and 68 Ill. Adm. Code 1305 must be updated, be maintained on file at each practice location, and be available upon the Department's request.

e) The APN must notify the Department within 10 business days if an agreement is dissolved or if a change occurs in the collaborating physician or practitioner under the agreement. The Department will then re-evaluate the APN's enrollment status.

f) The collaborating physician or practitioner is not required to be enrolled with the Department. However, the collaborating physician or practitioner may not be terminated, suspended or barred by the Department from participating in the Medical Assistance Program.

g) An APN who is required to maintain a collaborative or written practice agreement

must submit the following information with the initial application for enrollment:

1) Documentation of specialty of practice.

2) Collaborating physician's or practitioner's name and address.

3) Collaborating physician's or practitioner's Federal Employer Identification Number (FEIN).

4) Collaborating physician's or practitioner's medical license number.

5) Collaborating physician's or practitioner's state of licensure, if other than Illinois.

h) A CRNA who is not required to maintain a collaborative or written practice agreement and who provides services in a hospital or Ambulatory Surgical Treatment Center setting must submit with the initial application for enrollment the names and addresses of the hospitals or Ambulatory Surgical Treatment Centers where he or she practices.

i) To be eligible for reimbursement for psychiatric services, as defined in the American Medical Association Current Procedural Terminology (CPT) book, CPT code range 90801 through 90899, excluding 90853, the rendering APN must hold a current certification in Psychiatric and Mental Health Nursing as set forth in 68 Ill. Adm. Code 1305.Appendix A.

(Source: Amended at 33 Ill. Reg. 12227, effective October 1, 2009)

Section 140.436 Limitations on Advanced Practice Nurse Services

The following will not be reimbursed:

a) Nursing services provided in the role of physician assistant.

b) Mileage to and from place of service.

c) Consultations between APNs or between an APN and a physician.

d) Group psychotherapy or telepsychiatry.

(Source: Amended at 33 Ill. Reg. 12227, effective October 1, 2009)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.438 Diagnostic Imaging Services

a) Payment for diagnostic and imaging services may be made to the following providers that are independent of both a physician's office and a hospital:

1) Imaging Centers that are distinct entities operating primarily for the purpose of providing diagnostic imaging services.

2) Mammography Screening Centers.

3) Portable X-ray Facilities.

4) Independent Diagnostic Testing Facilities (IDTFs) that are a fixed location, a mobile entity, or an individual non-physician practitioner.

b) Participation Requirements

1) To participate in the Illinois Medical Assistance program, an Imaging Center must, in addition to any other Department requirements, be licensed or certified:

A) for participation in the Medicare program; or

B) by the Joint Commission on Accreditation of Health Care Organizations (JCAHO); or

C) by a state public health department; or

D) by any government agency having jurisdiction over the services provided and/or the equipment being used.

2) Portable X-ray Facilities shall be approved and certified for participation in the Medicare program.

3) Mammography Screening Centers shall be certified by the Illinois Department of Nuclear Safety or the certifying agency in the state where the center is located.

4) Independent Diagnostic Testing Facilities shall be approved and certified for participation in the Medicare program.

c) Reimbursement

1) Diagnostic and imaging services shall be reimbursed on a fee-for-service basis only.

2) Reimbursement may include the technical services, the professional services or both the technical and professional services.

3) Reimbursement shall be made for only those diagnostic or imaging services that have been ordered in writing by the referring practitioner as being essential to diagnosis and treatment. The practitioner must include the diagnosis or condition on the written request.

4) Reimbursement shall be made only to providers who meet all applicable license, enrollment and reimbursement conditions of the Department.

5) Reimbursement to IDTFs shall be made for only those diagnostic and imaging tests certified by Medicare.

6) Except for mammograms, reimbursement shall not be made for routine screening x-rays.

d) Record Requirements

1) In addition to the record requirements specified in Section 140.28, providers of diagnostic and imaging services must comply with the administrative rules of the Illinois Department of Public Health governing the maintenance of medical records (77 Ill. Adm. Code 450, Illinois Clinical Laboratories Code).

2) The basic records that must be retained include:

A) Patient identification.

B) Medical records containing the dates of service and the name of the referring physician.

C) The referring practitioner's written orders.

D) Copies of reports to referring practitioners.

E) The report of the reading by the professional practitioner if both professional and technical components are billed.

F) The report of the reading by the professional practitioner that must be retained in the professional practitioner's office if only the professional component is billed by the practitioner.

G) Records that verify usual and customary charges to the general public.

3) Medical records for Medical Assistance program clients must be made available to the Department or its designated representative in the performance of audits or investigations.

(Source: Amended at 35 Ill. Reg. 12909, effective July 25, 2011)

Section 140.440 Pharmacy Services

a) Payment shall be made only to pharmacies.

b) The following conditions apply to pharmacy participation:

1) The pharmacy must hold a current Drug Enforcement Administration (DEA) registration issued by the United States Drug Enforcement Administration (see 21 CFR 1301 et seq.), as well as a current controlled substances license issued by the Illinois Department of Professional Regulation (see Controlled Substances Act [720 ILCS 570]) prior to enrolling with the Department.

2) Licensed Pharmacy Requirements

A) A licensed pharmacy located in and/or administratively associated with a group practice or long-term facility must:

i) provide the same scope of general pharmacy and professional services as a pharmacy not so affiliated; and

ii) be retail in nature, open and accessible to the general public.

B) The pharmacy shall not limit prescriptions filled to those written by practitioners connected with the group or facility for persons receiving care or services from the group or facility.

3) A hospital pharmacy which provides pharmaceutical services and supplies for inpatients, outpatient clinic patients and emergency room patients of the hospital may not enroll as a participating pharmacy unless licensed to provide pharmaceutical services to the general public (Division 5 license).

c) The Department shall pay for the dispensing of pharmacy items, subject to the provisions of subsection (d) below and Section 140.443, which are prescribed by a physician, dentist or podiatrist within the scope of their professional practice.

d) Beginning with drugs dispensed on or after April 1, 1991, Department coverage shall be limited to those drug manufacturers having rebate agreements in effect as provided under Section 1927 of Title XIX of the Social Security Act (42 U.S.C. 1396s). The Department shall provide all interested parties with an updated list of drug manufacturers having rebate agreements in effect.

e) The Department may require approval for the reimbursement of any drug except as provided in Section 140.442. When reviewing requests for prior authorization, approval decisions shall be medically based. The Department's electronic claims processing system shall be the mechanism for identification of whether a prescribed drug requires prior authorization to dispensing pharmacists. A printed listing of prescribed drugs available without prior approval shall be provided to other interested parties upon request.

f) An approved request does not guarantee payment. The recipient for whom the services/items are approved must be eligible at the time they are provided. In addition, a valid, current prescription for the requested medication must be on file and maintained by the pharmacy in accordance with the Pharmacy Practice Act of 1987 [225 ILCS 85].

g) For purposes of Sections 140.440 through 140.448, pertaining to reimbursement for drugs, the following definitions apply:

1) Nursing facility means any facility which provides medical group care services as defined in Section 140.500.

2) Generic drug means those legend drugs which are multiple source drugs marketed or sold by two or more labelers, marketed or sold by the same labeler under two or more different proprietary names or marketed both under a proprietary name and without such a name.

3) Brand name drug means single-source innovator drugs and innovator multiple-source drugs when prior authorization has been obtained for reimbursing the innovator product.

(Source: Amended at 19 Ill. Reg. 16677, effective November 28, 1995)

Section 140.441 Pharmacy Services Not Covered

Items excluded from coverage include the following:

a) Drug products manufactured by drug manufacturers not meeting the rebate requirements of Section 140.440(d);

b) Anorectic drugs or combinations including such drugs;

c) Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies;

d) Any vaccine, drug or serum which is provided primarily for preventive purposes; e.g., influenza vaccine;

e) Drugs for injection in a practitioner's office unless the cost of the drug per injection (excluding administration) exceeds $25.00;

f) Drugs that have been classified by the Food and Drug Administration (FDA) as ineffective or unsafe in a final order;

g) Drugs that the Food and Drug Administration has proposed in a notice of opportunity for hearing to withdraw labeled indications [pursuant to Section 107(c)(3) of the Drug Amendments of 1962 (P.L. 87-781) and Section 505(e) of the Federal Food Drug and Cosmetic Act (21 USC 355 (e))] and any identical, related or similar drug products [determined by the FDA in accordance with 21 CFR 310.6];

h) Items identified as Group Care Restricted Items (see Section 140.449(b)) are not covered when provided to recipients living in licensed long-term care facilities;

i) Sickroom Needs and Medical Equipment Items are not covered as pharmacy items. A pharmacy which desires to provide such items must enroll as a provider of medical equipment; and

j) Miscellaneous Supplies which are stocked and dispensed by some pharmacies are not covered. These items include, but are not limited to, dental products, hair products, facial tissues, infant disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, proprietary food supplements or substitutes, sugar or salt substitutes, household products, or infant formula for routine feeding.

(Source: Amended at 16 Ill. Reg. 4006, effective March 6, 1992)

Section 140.442 Prior Approval of Prescriptions

a) The Department may require prior approval for the reimbursement of any drug, except as provided in this Section. Determinations of whether prior approval for any drug is required shall be made in the following manner:

1) The Department shall consult with individuals or organizations which possess appropriate expertise in the areas of pharmacology and medicine. In doing so, the Department shall consult with organizations composed of physicians, pharmacologists, or both, and shall, to the extent that it consults with organizations, limit its consultations to organizations which include within their membership physicians practicing in all of the representative geographic areas in which recipients reside and practicing in a majority of the areas of specialization for which the Department reimburses physicians for providing care to recipients.

2) The Department shall consult with a panel from such organizations (the panel is selected by such organizations) to review and make recommendations regarding prior approval. The panel shall meet not less than four times a year for the purpose of the review of drugs. The actions of the panel shall be non-binding upon the Department and can in no way bind or otherwise limit the Department's right to determine in its sole discretion those drugs which shall be available without prior approval.

3) Upon U.S. Food and Drug Administration approval of a new drug, or when post-marketing information becomes available for existing drugs requiring prior approval, the manufacturer shall be responsible for submitting materials to the Department which the Department and the consulting organization shall consider in determining whether reimbursement for the drug shall require prior approval.

4) New dosage strengths and new dosage forms of products currently included in the list of drugs available without prior approval (see Section 140.440(e)) shall be available without prior approval upon the request of the manufacturer, unless otherwise designated by the Director. In such a case, the Director shall submit the new dosage strength, or new form, to the prior approval procedures described in this Section.

5) Upon receipt of the final agenda established for each meeting of the panel created under subsection (a)(2), the Department shall promptly review materials and literature supplied by drug manufacturers. Additional literature may be researched by the Department to assist the panel in its

review of the products on the agenda. The Department shall make comments and, within ten working days after receipt of the agenda, transmit such comments either in person or in writing to the panel. This shall be done for each meeting of the above described panel.

6) The consulting organization shall transmit its recommendations to the Department in writing.

7) Upon receipt of this transmittal letter, the Department shall, within 15 business days, notify all interested parties, including pharmaceutical product manufacturers, of all recommendations of the consulting organization accepted or rejected by the Director. Notifications to pharmaceutical manufacturers of the Director's decision to require prior approval shall include reasons for the decision. Decisions requiring prior approval of new drug products not previously requiring prior approval shall become effective no sooner than ten days after the notification to providers and all interested parties, including manufacturers. The Department shall maintain a mailing list of all interested parties who wish to receive a copy of applicable notices.

8) Drug manufacturers shall be afforded an opportunity to request reconsideration of products recommended for prior approval. The Drug manufacturers may submit whatever information they deem appropriate to support their request for reconsideration of the drug product. All reconsideration requests must be submitted in writing to the Department and shall be considered at the next regularly scheduled meetings of the expert panel created under subsection (a)(2) convened by the consulting organization.

9) The Department shall provide that the following types of drugs are available without prior approval:

A) Drugs for the treatment of Acquired Immunodeficiency Syndrome (AIDS) which the Federal Food and Drug Administration has indicated is subject to a treatment investigational new drug application;

B) Contraceptive drugs and products;

C) Oncolytic drugs; and

D) Non-innovator products, listed in the State of Illinois Drug Product

Selection Program's current Illinois Formulary, when the innovator product is available without prior approval.

b) Except as provided in subsection (c), prior approval shall be given for drugs requiring such authorization if:

1) The drug is a legend item (requires a prescription); and

2) The drug is used in accordance with predetermined standards consistent with the compendia consisting of the American Hospital Formulary Service Drug Information, the United States Pharmacopeia – Drug Information and the American Medical Association Drug Evaluations, as well as the peer-reviewed medical literature; and

3) Either:

A) The drug is necessary to prevent a higher level of care, such as institutionalization; or

B) The prescriber has determined that the drug is medically necessary.

c) For recipients covered by the General Assistance Medical Program, prior approval shall be given for drugs requiring such authorization if:

1) The drug is a legend item (requires a prescription); and

2) The drug is used in accordance with predetermined standards consistent with the compendia consisting of the American Hospital Formulary Service Drug Information, the United States Pharmacopeia – Drug Information and the American Medical Association Drug Evaluations, as well as the peer-reviewed medical literature; and

3) The physician has documented that the requested item is necessary to prevent a life threatening situation and that items covered under the basic health protection plan are not effective to maintain the patient's life or to avoid the life threatening situation.

d) Decisions on all requests for prior approval by telephone or other telecommunications device and, upon the Department's receipt of such request, shall be made by the same time of the Department's next working day. In an emergency situation, the Department shall provide for the dispensing of at least a 72-hour supply of a covered prescription drug.

e) In accordance with subsection (e)(2), the Department may require prior approval prior to reimbursement for a brand name prescription drug if the patient for whom the drug is prescribed has already received three brand name prescription drugs in the preceding 30-day period, and is 21 years of age or older.

1) For purposes of this subsection (e), brand name prescription drugs in the following therapeutic classes shall not count towards the limit of three brand name prescription drugs and shall not be subject to prior approval requirements because a patient has received three brand name prescription drugs in the preceding 30 days.

A) Antiretrovirals;

B) Antineoplastics;

C) Anti-Rejection Drugs;

D) Antipsychotics;

E) Anticonvulsants;

F) Insulin; and

G) Anti-Hemophilic Factor Concentrates.

2) Brand name prescription drugs are exempt from the prior approval requirements of subsection (e) if:

A) there are no generic therapies for the condition treated within the same therapeutic drug class; or

B) the Department determines that the brand name prescription drug is cost effective.

(Source: Amended at 30 Ill. Reg. 2802, effective February 24, 2006)

Section 140.443 Filling of Prescriptions

a) The prescription must contain the information required under Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23) and also contain the prescriber's:

1) Drug Enforcement Administration (DEA) Number; or

2) National Provider Identifer (NPI); or

3) Medical Assistance Program Provider Number; or

4) Illinois State License Number.

b) To the extent required by federal law, effective with new prescriptions executed on or after April 1, 2008, for clients covered under Title XIX of the Social Security Act, a non-electronic prescription must be written on a tamper-resistant prescription pad to be eligible for reimbursement. This requirement applies to all prescriptions regardless of whether the Department is the primary payor.

1) Non-electronic prescriptions are prescriptions that are not transmitted from the prescriber to the pharmacy via telephone, telefax, electronic prescribing (e-prescribing) mechanism, or other means of electronic transmission.

2) Effective April 1, 2008, a prescription form is considered tamper-resistant when it contains any of the following characteristics and, effective October 1, 2008, to be considered tamper-resistant, a prescription form must contain all of the following characteristics:

A) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank form;

B) one or more industry-recognized features to prevent the erasure or modification of information written on the prescription by the prescriber;

C) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

3) If a patient presents at a pharmacy with a prescription written on a prescription pad that is not tamper-resistant, and the pharmacist contacts

the prescriber via telephone, telefax, or other electronic communication device, and the prescriber or the prescriber's agent verifies the validity of the prescription, the prescription is then considered "electronic" and, therefore, exempt from the requirement that the prescription be written on a tamper-resistant pad. In such cases, the pharmacist shall note on the original prescription that the prescriber was contacted and the prescriber or the prescriber's agent verified the validity of the prescription.

4) If a patient presents at a pharmacy with a non-electronic prescription written on a pad that is not tamper-resistant, and the pharmacist is unable to contact the prescriber or the prescriber's agent to verify the validity of the prescription, and the pharmacist, in using his or her professional judgment, determines that not filling the prescription poses a health risk to the patient, the pharmacist may fill the prescription and the Department will reimburse for the prescription, provided that the patient is eligible for coverage of the drug and provided that the drug is covered by the Department. The pharmacist must obtain from the prescriber or the prescriber's agent a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled.

c) Pharmacies shall not accept blank, presigned prescription forms.

d) If a drug is available by generic name and the identical drug is prescribed by trade name, payment will be based on cost of the generic product unless prior authorization has been obtained for reimbursement based upon the innovator product, or unless the Department determines that the innovator product, reimbursed at the brand name pricing methodology, is more cost-effective than the generic equivalent.

e) The Department shall not pay for dispensed items in excess of the maximum quantity established by the Department, unless prior approval has been granted to dispense an amount in excess of the maximum. The Department shall pay for no more than one month's supply of the item dispensed.

f) The Department shall pay for refills only if the prescribing practitioner authorized refills on the original prescription in accordance with State law.

g) Pharmacies may use a unit dose system in the dispensing of drugs when such a system is in compliance with all applicable State and Federal laws. The total quantity dispensed on one prescription cannot exceed the quantity prescribed or the maximum allowable quantity.

(Source: Amended at 33 Ill. Reg. 9048, effective June 15, 2009)

Section 140.444 Compounded Prescriptions

a) Pharmacy charges for compounded prescriptions shall be billed at the per ingredient charge to the general public.

b) Reimbursement will be at the lower of the pharmacy's charge or the Department's maximum for each ingredient.

(Source: Amended at 19 Ill. Reg. 16677, effective November 28, 1995)

Section 140.445 Legend Prescription Items (Not Compounded)

For legend (prescription) drugs, the Department shall pay the lower of:

a) the pharmacy's prevailing charge to the general public; or

b) the Department's maximum price plus the established dispensing fee of $4.60 for generic drugs and $3.40 for brand name drugs.

1) For generic drugs, the Department's maximum price is calculated as the lowest of:

A) the average wholesale price minus 25 percent; or

B) the Federal Upper Limit for drugs that have been evaluated as therapeutically equivalent in the Food and Drug Administration's publication entitled Approved Drug Products with Therapeutic Equivalence Evaluations; or

C) the State Upper Limit for drugs listed in the Illinois Formulary for the Drug Product Selection Program and not having an established Federal Upper Limit at the time of listing; or

D) the average wholesale price for drugs where that price is based upon the actual market wholesale price.

2) For brand name drugs, the Department's maximum price is calculated as the lower of:

A) the average wholesale price minus 12 percent; or

B) the average wholesale price for drugs where that price is based upon the actual market wholesale price.

(Source: Amended at 26 Ill. Reg. 17751, effective November 27, 2002)

Section 140.446 Over-the-Counter Items

For those over-the-counter items which are covered, the Department shall pay the lower of:

a) the prevailing charge to the general public; or

b) the average wholesale price plus 25 percent.

(Source: Amended at 25 Ill. Reg. 6665, effective May 11, 2001)

Section 140.447 Reimbursement

a) The calculation of average wholesale price in the determination of the Department's maximum price (Section 140.445(b)) is made using the standard package size.

b) If a pharmacy gives discounts to the general public, it must provide the same to Public Aid recipients. If discounts are allowed only to a specific group of people, they shall be extended to a recipient if he or she is a member of the special discount group. Public Aid recipients can constitute a special group and receive a discount, but they cannot be excluded from a discount group just because they are recipients.

c) The Department will require pharmacies to complete hard copy (paper) claim forms for pharmacy services and attach a Prescribing Practitioner Name Identification Form. A separate hard copy (paper) claim form and Practitioner Name Identification Form is to be required for each recipient and prescribing practitioner.

d) The Department will authorize an exception for pharmacies, to the requirements of subsection (c) of this Section, by allowing pharmacy claims to be submitted with the prescribing practitioner's DEA number, Department Medical Assistance Program participating provider identification number or Social Security Number.

(Source: Amended at 25 Ill. Reg. 14975, effective November 1, 2001)

Section 140.448 Returned Pharmacy Items

The Department shall not pay for an unused pharmacy item returned to the dispensing pharmacy by or on behalf of a recipient, due to a change in prescription, death of a recipient, etc., when the item can be accepted by the pharmacy in accordance with applicable Federal and State laws and regulations.

Section 140.449 Payment of Pharmacy Items

a) The Department shall pay no more for charges submitted than the maximum permitted by Federal regulations.

b) Explanation of drug restrictions

1) Group Care and General Assistance Restricted – The drug is available to all recipient categories except recipients of General Assistance and individuals residing in a nursing home.

2) The nursing home must provide the following listed drugs to resident recipients at no charge to the recipient:

Acetaminophen Drops 80MG/0.8ML

Acetaminophen Drops 120MG/2.5ML

Acetaminophen Elixir/Syrup 120MG/5ML

Acetaminophen Tab/Cap 325MG

Acetaminophen Tab/Cap 500MG

Acetaminophen Tab/Cap 650MG

Acetaminophen Tablet Chewable 80MG

Acetaminophen Tablet Chewable 120MG

Aspirin Tab Buffered 325MG

Aspirin Tab Buffered 600MG

Aspirin Tab Ec 300MG

Aspirin Tab Ec 600MG

Aspirin Tab Pediatric

Aspirin Tab 300MG

Aspirin Tab 600MG

Glucola Liquid

Milk of Magnesia Liquid

Milk of Magnesia Tablet

Zinc Oxide Ointment

c) No restrictions – The drug is available to all recipient categories including nursing home residents and recipients of basic health coverage.

d) Group Care Restricted – The drug is available to all recipients except recipients residing in nursing homes. The nursing home must provide the following listed items to resident recipients at no charge to the recipient:

Acetest Reagent Tablets

Albustix Strips

Chemstrip BG Strips

Chemstrip GP

Chemstrip K Papers

Chemstrip Test Kit

Chemstrip UG Strips

Chemstrip UGK Strips

Chemstrip 5

Clinistix Strip

Clinitest (2 Drop)

Clinitest Analysis Set

Clinitest Analysis Set (2 Drop)

Clinitest Tablet

Clinitest Tablet Foil

Combistix

Dextrostix Reagent Strips

Dextrostix Reagent Strips Foil

Diascan Dual Pad Strips

Diastix Strips

Exactech Test Strips

Glucofilm Test Strips

Glucoscan Test Strips

Glucostix Strips

Hema-Combistix

Hemastix Strips

Hematest Tablet

Keto-Diastix

Keto-Diastix 5

Ketostix Strips

Labstix

Lancet for Diabetic Use, Sterile

N-Uristix

One Touch Test Strips

Tes-Tape

Tracer Bg Strips

Trendstrips

Uristix

Visidex II Reagent Strips

Any product equivalent to those on the above list or any other nonlisted diabetic testing supply

e) Group care limited – The drug is available only to recipients residing in nursing homes.

(Source: Amended at 16 Ill. Reg. 4006, effective March 6, 1992)

Section 140.450 Record Requirements for Pharmacies

a) Pharmacies shall retain the following basic records:

1) All original prescriptions for Public Aid recipients;

2) All invoices from all suppliers from which the pharmacy acquires goods for which charges are made to the Department; and

3) A method of verification of usual and customary charges to the general public; and

4) A signature log as described in subsection (c) of this Section.

b) A pharmacy shall permit access to these records by authorized Department personnel on request, and shall retain such financial records as are necessary to substantiate acquisition costs for a period of not less than three years from the date of service.

c) A pharmacy shall maintain a log of signatures for the receipt or pick up of prescriptions by the person receiving the prescription. Such log shall list each prescription by prescription number, the date the prescription was picked up and the signature of the person picking up the prescription, except that one signature is sufficient when picking up multiple prescriptions for a single individual. The original prescription must be maintained and match the prescription number on the log.

d) As an alternative to maintaining the signature log described in subsection (c) of this Section, a pharmacy may opt to utilize optical scanner bar technology to document that prescriptions were, in fact, received or picked up. At the Department's request, any pharmacy choosing to utilize optical scanner bar technology must be able to produce paper copies of the information retained electronically through the use of this technology.

e) For pharmacies providing drugs via mail order, a shipping log may be used as an alternative to the signature log described in subsection (c) of this Section. This mail order shipping log, which may be maintained electronically, must contain the patient's name, address, prescription number, date the prescription was shipped, and the name and/or type of carrier. At the Department's request, any pharmacy choosing to maintain its mail order shipping log electronically must be able to produce paper copies of the information retained in said shipping log.

f) For pharmacies providing drugs to patients residing in a long term care facility licensed by the Illinois Department of Public Health, the pharmacy shall maintain a signature log as described in subsection (c) of this Section, except that one signature is sufficient for all the medications delivered for a patient and a facility staff member may sign for the receipt of the drugs. Both the facility and the pharmacy are accountable for ensuring the accuracy of the information in the log.

g) For pharmacies providing drugs to patients who are receiving medications in their homes with the assistance of a home health agency or hospice licensed by the Illinois Department of Public Health, or a registered nurse licensed by the Illinois Department of Professional Regulation, the pharmacy shall maintain a signature log as described in subsections (c) and (f) of this Section, except that one signature is sufficient for all the medications delivered for a patient and a home health agency representative or hospice representative may sign for the receipt of the drugs. Both the pharmacy and the home health agency or hospice are accountable for ensuring the accuracy of the information in the log.

h) The information required in subsections (c), (f) and (g) of this Section may be kept in an electronic form, including electronic signatures, provided that paper copies of the information, including signatures, can be printed from the electronic file.

(Source: Amended at 28 Ill. Reg. 4958, effective March 3, 2004)

Section 140.451 Prospective Drug Review and Patient Counseling

Each pharmacy must ensure that:

a) The requirements for patient counseling established by the Illinois Department of Professional Regulation at 68 Ill. Adm. Code 1330.65, including the requirements of confidentiality and documentation of refusal of offers of patient counseling by recipients, are met on a continuing basis.

b) Before each prescription is delivered to the recipient or the recipient's care giver, a pharmacist must ensure that a review of the recipient's drug therapy (prospective drug review or drug utilization evaluation) was performed using commonly accepted drug review criteria. The review must include screening to identify potential drug therapy problems of the following types:

1) Therapeutic duplication, including the prescribing and dispensing of two or more drugs from the same therapeutic class such that the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program costs without additional therapeutic benefit;

2) Drug-disease contraindication when there is the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a given drug because of the presence of a disease condition known to the pharmacist or that may reasonably be expected to be known to the pharmacist, or an adverse effect of the drug on the patient's disease condition;

3) Adverse drug-drug interaction when there is the potential for, or occurrence of, a clinically significant adverse medical effect as the result of the recipient using two or more drugs together;

4) Perceived incorrect drug dosage or duration; and

5) Drug-allergy interactions.

c) Commonly accepted drug review criteria are those criteria that are consistent with peer-reviewed medical literature (that is, scientific, medical and pharmaceutical publications in which original manuscripts are rejected or published only after having been critically reviewed by unbiased independent experts) and the following compendia:

1) American Hospital Formulary Service Drug Information;

2) United States Pharmacopeia – Drug Information;

3) American Medical Association Drug Evaluations;

4) DRUG DEX Information System; and

5) Facts and Comparisons.

(Source: Added at 22 Ill. Reg. 16302, effective August 28, 1998)

Section 140.452 Mental Health Services

a) Payment will be made for mental health services provided by providers:

1) certified as being in compliance with standards set forth in 59 Ill. Adm. Code 132; or

2) certified as being compliant with standards set forth in 59 Ill. Adm. Code 132 and under a multi-agency contract with the Department, DCFS and DHS to provide Screening, Assessment and Support Services (SASS).

b) To receive payment for mental health services, providers must be enrolled for participation in the Medical Assistance Program pursuant to Sections 140.11 and 140.12.

(Source: Amended at 28 Ill. Reg. 15513, effective November 24, 2004)

Section 140.453 Definitions

Words which are defined in 59 Ill. Adm. Code 132.25 have the same meaning when used in Sections 140.452 through 140.456.

"DCFS" means the Illinois Department of Children and Family Services.

"DHS" means the Illinois Department of Human Services.

"Screening, Assessment and Support Services (SASS)" means a program of intensive mental health services provided by an agency certified by DHS or DCFS to provide screening, assessment and support services to children with a mental illness or emotional disorder who are at risk for psychiatric hospitalization.

(Source: Amended at 28 Ill. Reg. 15513, effective November 24, 2004)

Section 140.454 Types of Mental Health Services

The specific types of mental health services for which payment will be made are:

a) Mental health services meeting the standards in 59 Ill. Adm. Code 132;

b) The screening and assessment authorized under 59 Ill. Adm. Code 131.40 for clients under 21 years of age; and

c) The crisis intervention and stabilization services authorized under 59 Ill. Adm. Code 131.50(a) for a period not to exceed 90 days for clients under 21 years of age.

d) Subject to prior approval pursuant to Section 140.40, case management services for individuals, identified through the screening process specified in Section 140.642, transitioning from a nursing facility into residence in the community.

e) Developmental testing for an infant and risk assessment screening for perinatal depression, for either the mother (prenatal or post-partum) or the infant, up to one year after delivery.

(Source: Amended at 33 Ill. Reg. 11287, effective July 14, 2009)

Section 140.455 Payment for Mental Health Services

a) The amount approved for payment for mental health services described in Section 140.454 shall be based on the type and amount of service required by and actually delivered to a client.

b) The payment amount for a service described in Section 140.454(a) through (c) is determined in accordance with the rate methodologies outlined in 59 Ill. Adm. Code 132.60.

c) The payment amount for a service described in Section 140.454(e) shall be at the rate of reimbursement paid to a physician for the same service.

(Source: Amended at 33 Ill. Reg. 11287, effective July 14, 2009)

Section 140.456 Hearings

The Department shall initiate administrative proceedings pursuant to 89 Ill. Adm. Code 104, Subpart C, and Sections 140.13 through 140.19 to suspend or terminate the eligibility of providers of mental health clinic services to participate in the Illinois Medical Assistance Program where:

a) The provider has failed to comply with 59 Ill. Adm. Code 132; and/or

b) Any of the grounds for termination set forth in Section 140.16 are present.

(Source: Amended at 28 Ill. Reg. 15513, effective November 24, 2004)

Section 140.457 Therapy Services

Therapy Covered Services: Physical, occupational and speech/language services are provided for clients because of illness, disability or infirmity and in accordance with a plan established by a physician and reviewed by the physician every 90 days. Payment may be made for therapy services provided by:

a) A physical, speech or occupational therapist who is qualified as follows:

1) A physical therapist must be licensed by the Department of Professional Regulation.

2) A speech/language therapist must be licensed by the Illinois Department of Professional Regulation.

3) An occupational therapist must be licensed by the Department of Professional Regulation.

b) A community health agency.

(Source: Added at 15 Ill. Reg. 6220, effective April 18, 1991)

Section 140.458 Prior Approval for Therapy Services

a) Prior approval is required for the provision of services by an independent speech/language, physical or occupational therapist or by a community health agency, unless:

1) the individual is eligible for services under Medicare; or

2) services are provided in accordance with initial treatment guidelines outlined in the provider manual; or

3) the individual has been hospitalized within the past 30 days and was, while hospitalized, receiving therapy services; or

4) therapy services are being provided as a result of a Healthy Kids diagnosis and referral (89 Ill. Adm. Code 140.485).

b) Approval will be granted when, in the judgement of a consulting physician and/or professional staff of the Department, the services are medically necessary and appropriate to meet the individual's medical needs.

c) The decision to approve or deny a request for prior approval will be made within 21 days of the date the request and all necessary information is received.

(Source: Added at 15 Ill. Reg. 6220, effective April 18, 1991)

Section 140.459 Payment for Therapy Services

Therapy services shall be paid at an all-inclusive per half-hour rate which shall be the lower of:

a) The providers usual and customary charge for services; of

b) The maximum reimbursement rate established by the Department.

(Source: Added at 15 Ill. Reg. 6220, effective April 18, 1991)

Section 140.460 Clinic Services

The following types of clinics are eligible to receive payment for clinic services:

a) Hospital-based organized clinics;

b) Encounter rate clinics;

c) Federally Qualified Health Centers (FQHC);

d) Rural health clinics;

e) Mental health clinics (see Sections 140.452 through 140.456); and

f) Maternal and Child Health Clinics.

(Source: Amended at 20 Ill. Reg. 4345, effective March 4, 1996)

Section 140.461 Clinic Participation, Data and Certification Requirements

a) Hospital-based organized clinics must:

1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care;

2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers;

3) Meet the following requirements:

A) be adjacent to or on the premises of the hospital and be licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or

B) have provider-based status under Medicare pursuant to 42 CFR 413.65; or

C) be clinically integrated as evidenced by the following:

i) professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital; and

ii) fully integrated within the financial system of the main

hospital, as evidenced by shared income and expenses between the main hospital and the clinic; and

iii) held out to the public and other payers as part of the main hospital; and

iv) operated under the ownership and control of the main hospital, as evidenced by the following: the business enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic; and

v) located within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.

4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).

b) Encounter rate clinics must participate in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998, or be a clinic operated by a county with a population of over three million. Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Maternal and Child Health Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2).

c) Rural health clinics must be certified by the Health Care Financing Administration as meeting the requirements for Medicare participation.

d) Federally Qualified Health Centers (FQHC):

1) Must be Health Centers which:

A) receive a grant under Section 329, 330 or 340 of the Public Health Service Act; or

B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are

determined to meet the requirements for receiving such a grant.

2) Section 4602 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which amended Section 1902(a)(55) of the Social Security Act (42 USC Section 1396a(a)(55)), requires states to receive and initially process Medicaid applications from low-income pregnant women and children under 19 years of age at locations other than the local Department of Human Services (DHS) office. Such a site is referred to as an outstation.

A) Outstations will be located at those FQHCs which the Department determines serve heavy Medicaid populated areas. For areas in which the Department determines that maintaining outstation workers is not economical, the DHS local office will continue to be the application location.

B) The FQHCs, which will provide outstation eligibility staff to accept and assist in the initial processing of the Medicaid application for pregnant women and children, will forward the completed application to the appropriate DHS local office. Initial processing means accepting and completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews. Neither the FQHCs nor the outstation workers will evaluate the information contained on the application, nor make any determination of eligibility or ineligibility. The DHS local office is responsible for these functions.

C) Costs allowable under the federal outstation mandate for completing the Medicaid application will be itemized in Section B of Schedule I of the FQHC Medicaid cost report and will be provided annually in the FQHC cost reporting process. These allowable costs will be collected, computed and calculated, and will result in the establishment of an outstation administrative rate and a Medicaid rate. The allowable costs are:

i) Salary of outstation worker;

ii) Fringe benefits;

iii) Training;

iv) Travel; and

v) Supplies.

D) FQHC outstation workers must receive certification through Maternal and Child Health (MCH) process training by the Department before they begin to perform eligibility processing functions. Failure to become certified results in any MCH application completed by an ineligible worker being non-allowed on the cost report.

E) FQHCs must have adequate staff trained with proper backup to accommodate unforeseen problems. FQHCs must be able to meet the demand of this initiative, either using staff at one location or rotating staff as dictated by workload or staffing availability. The FQHC must have staff available at each outstation location during regular office operating hours.

F) Outstation intake staff may perform other FQHC intake processing functions, but the time spent on outstation activities must be documented and must be identifiable for cost reporting and auditing purposes.

G) The FQHC must display a notice in a prominent place at the outstation location advising potential applicants of the times that outstation intake workers will be available. The notice must include a telephone number that applicants may call for assistance.

H) The FQHC must comply with federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.

f) Maternal and Child Health Clinics

1) Types of Clinics
The following clinics shall qualify as Maternal and Child Health Clinics:

A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC) that are hospital-based organized outpatient clinics, as described in

subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide ambulatory primary care to Medicaid children from birth through 20 years of age, and pregnant women in a non-emergency room setting. At least 50 percent of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHAPCC must be for primary care.

B) Certified Hospital Organized Satellite Clinics (CHOSC) that are clinics meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that are owned, operated, and/or managed by a hospital but do not qualify as hospital-based organized clinics, as described in subsection (a), because they are not located adjacent to or on the premises of the hospital or are not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency setting to Medicaid children from birth through 20 years of age, and to pregnant women. At least 50 percent of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized expertise necessary for the provision of secondary and tertiary care. CHOSCs shall meet the requirements in subsections (a)(1) and (a)(2).

C) Certified Obstetrical Ambulatory Care Centers (COBACC) that are hospital-based organized clinic entities, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide primary care and specialty services to Medicaid-eligible pregnant women, especially those determined to be non-compliant or at high risk, in an outpatient setting.

D) Certified Pediatric Ambulatory Care Centers (CPACC) that are hospital-based organized clinic entities, as described in subsection (a), owned and operated by a hospital as described in 89 Ill. Adm. Code 149.50(c)(3), and meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide pediatric primary care and specialty services as described in Section 140.462(e)(3)(C) to Medicaid enrolled children with specialty needs, from birth through 20 years of age in an outpatient setting. Hospitals with CPACCs must also provide primary care for at least 1,500 children, either through its CPACC or through a CHAPCC, CHOSC or encounter rate clinic operated by the same hospital. Hospitals unable to meet this volume requirement must agree to serve as a specialty referral site for another hospital operating a CPACC through a written agreement submitted to the Department.

2) General Participation Requirements
In addition to the Maternal and Child Health participation requirements described in Section 140.924(a)(1), the Maternal and Child Health clinics identified in subsection (f)(1) must:

A) Be operated by a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 pregnant women or children; or be a primary care teaching site of an organized academic department of:

i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.

ii) In the case of clinics described in subsection (f)(1)(C), an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.

iii) In the case of clinics described in subsection (f)(1)(D), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.

B) Under the direction of a board certified/eligible physician who has hospital admitting and/or delivery privileges and provides direct supervision to residents practicing in the certified ambulatory site, provide:

i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), primary care.

ii) In the case of clinics described in subsection (f)(1)(C), obstetric and specialty services.

iii) In the case of clinics described in subsection (f)(1)(D), primary care and specialty services.

C) Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO);

D) Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department; and

E) Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality.

3) Special Participation Requirements
In addition to the Maternal and Child Health provider participation requirements described in Section 140.924(a)(1), and the general participation requirements described in subsection (f)(2), special participation requirements shall apply as follows:

A) Clinics described in subsections (f)(1)(A) and (f)(1)(B) must:

i) Serve a total population that includes at least 20 percent Medicaid and medically indigent clients;

ii) Perform a risk assessment on pregnant women assigned to them in order to determine if the woman is at high risk; and

iii) Provide or arrange for specialty services when needed by pregnant women or children.

B) Clinics described in subsection (f)(1)(C) must:

i) Be a distinct department of a hospital that also operates as a Level II, Level II with Extended Neonatal Capabilities or Level III perinatal center;

ii) Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to women who currently are Medicaid clients, or Medicaid-eligible women who receive services at the COBACC; in this capacity, COBACCs, as perinatal centers, shall serve pregnant women determined to be at high risk of abnormal delivery;

iii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;

iv) Have an established program of services for the treatment of substance-abusing pregnant women;

v) Integrate an accredited obstetrical residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and

vi) Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.

C) Clinics described in subsection (f)(1)(D) must:

i) Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition as described in Section 140.462(e)(3)(C);

ii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of pediatric emergencies;

iii) Provide access to necessary pediatric primary and specialty services within 24 hours after referral;

iv) Be a distinct department of a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120(a)(5);

v) Integrate an accredited pediatric or family practice residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty needs; and

vi) Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.

4) Data Requirements
The Maternal and Child Health clinics described in subsection (f)(1) shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.

5) Certification Requirements
Certification of qualifying status of a Maternal and Child Health clinic identified in subsection (f)(1) shall occur annually during the first two years of participation and every other year thereafter. In addition:

A) The certification process shall consist of a review of the completed application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on-site by Department staff within 60 days after application approval. Final notification of certification status shall be rendered within 30 days after the site review, pending provider submittal of a written plan of correction

for any deficiencies discovered during the entire application process.

B) Entities interested in becoming a Maternal and Child Health clinic must direct a written request for an application packet to the following address:

Maternal and Child Health Clinic Certification
Bureau of Comprehensive Health Services
Illinois Department of Public Aid
201 South Grand Avenue East, Concourse
Springfield, Illinois 62763-0001

C) Certification status shall be suspended for Maternal and Child Health clinics identified in subsection (f)(1) that do not submit data to the Department, as required under subsection (f)(4), within 180 days after the Department's request for the submittal of such data.

g) School Based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 Ill. Adm. Code 2200). Examples of certification requirements include:

1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.

2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.

3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners (see Section 140.400), must be under the direction of a physician.

4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with

hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.

5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will provide ongoing monitoring to assure that appropriate standards are followed.

6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.

7) The center must establish procedures for the availability of primary care providers and for 24-hour per day, 12-month per year access to routine, urgent and emergency care, telephone appointments and advice. The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24-hour back-up services when the center is not open.

8) Services may be provided to eligible students who have obtained written parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.

9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.

10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE)

enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.

A) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider or MCE to obtain a referral for a specialist.

B) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.

11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.

12) Data Requirements
The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

h) Hospital Outpatient Departments
Hospital outpatient departments may include facilities that meet the requirements of subsection (a)(3) of this Section.

(Source: Amended at 35 Ill. Reg. 10000, effective June 15, 2011)

Section 140.462 Covered Services in Clinics

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-Based Organized Clinics

1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e), as appropriate.

2) With respect to all other hospital-based organized clinics, covered services are those described in 89 Ill. Adm. Code 148.

b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924(a)(2)(B), covered services are those described in Section 140.922.

2) With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.

c) Rural Health Clinics

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants.

2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) speech and hearing services;

I) x-ray services;

J) health education;

K) nutrition services;

L) optometric services.

4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services.

d) Federally Qualified Health Centers
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants.

2) Other services for which separate encounters may be billed include dentists and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) optometric services;

I) speech and hearing services;

J) x-ray services;

K) health education;

L) nutrition services.

4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided.

e) Maternal and Child Health Clinics
Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:

1) In the case of clinics described in Section 140.461(f)(1)(A) and (f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:

A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;

B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;

C) Regular immunizations for the prevention of childhood diseases;

D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;

E) Routine prenatal care, including risk assessment, for pregnant women; and

F) Specialty care as medically needed.

2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:

A) Prenatal care, including risk assessment (one risk assessment per pregnancy);

B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and

C) Services to pregnant women with diagnosed substance abuse or addiction problems.

3) In the case of clinics described in Section 140.461(f)(1)(D):

A) Comprehensive medical and referral services.

B) Primary care services, which must include, but are not necessarily limited to:

i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;

ii) regular immunizations for the prevention of childhood diseases; and

iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.

C) Pediatric specialty services, which must include, at a minimum, necessary treatment for:

i) asthma,

ii) congenital heart disease,

iii) diabetes, and

iv) sickle cell anemia.

D) Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.

f) School Based/Linked Health Clinics (Centers)
Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(g):

1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical Practice and Pharmacy Practice Acts; and acute management and on-going

monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 35 Ill. Reg. 7962, effective May 1, 2011)

Section 140.463 Clinic Service Payment

a) Definitions

"Behavioral Health Services", for the purposes of this Section, means services provided by a licensed clinical psychologist, licensed clinical social worker or licensed clinical professional counselor.

"Center", for the purposes of this Section, means both a federally qualified health center and a rural health clinic.

"Federally Qualified Health Center" or "FQHC" means a health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Services Administration, U.S. Department of Health and Human Services.

"Rural Health Clinic" or "RHC" means a health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) (42 USC 1395x(aa)(2)) to be an RHC.

b) Reimbursement
The Center will be reimbursed under a prospective payment system for 100 percent of the average of the costs that are reasonable and related to the cost of furnishing such services by the Center in accordance with the provisions of federal law (42 USC 1396a(aa)). Baseline payment rates will be determined individually for each enrolled Center. Once determined, the baseline payment rate will be adjusted annually using the Medicare Economic Index (MEI). Payment for services provided on or after January 1, 2001, shall be made using specific rates for each Center as specified in this Section.

1) Baseline Payment Rates

A) For each Center, the Department will calculate a baseline medical encounter rate and, for each Center that is enrolled with the Department to provide Behavioral Health Services or dental services, the Department will calculate a baseline Behavioral Health Services or dental encounter rate, using the methodology specified in this subsection (b).

i) The cost basis for the baseline rates shall be drawn from individual Center cost reports for Center fiscal years ending in 1999 and 2000 or, in the instance of a Center that did not operate during the entirety of those periods, cost reports that cover the portions of those periods during which the Center was in operation.

ii) Pending federal approval, for dates of service provided by an FQHC on or after January 1, 2006, the cost basis for the baseline rates shall be the greater of an encounter rate using the criteria under subsection (b)(1)(A)(i) of this Section, or the same criteria that uses the Center's cost reports ending in 2002 and 2003 in place of cost reports ending in 1999 and 2000.

B) The baseline payment rates shall be based upon allowable costs, reported by the Center, that are determined by the Department to be reasonable and efficient. The method for determining allowable cost factors is similar to that used for Medicare (42 USC 1395g), with the following significant differences. The Department's methodology shall:

i) Consider costs associated with services not covered under Medicare (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling).

ii) Apply reasonable constraints on allowable cost, as described in subsection (b)(10) of this Section.

iii) Apply reasonable constraints on the total cost per encounter.

C) The baseline payment rates for a Center shall be the average (arithmetic mean) of the annual reasonable costs per encounter, calculated separately for each of the fiscal years for which cost report data must be submitted using the methodology specified in subsections (b)(2), (3) and (4) of this Section for the medical encounter rate, dental encounter rate, and Behavioral Health Services encounter rate, respectively.

2) Annual Reasonable Cost Per Medical Encounter

A) The annual reasonable cost per medical encounter shall be the lesser of:

i) The annual cost per encounter, as calculated in subsection (b)(2)(D) of this Section; or

ii) The reasonable cost of providing a medical encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) The core services component.
The core services component is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost, as defined in subsection (b)(1)(B) of this Section, for core services divided by the greater of the number of encounters reported by direct staff (e.g., staff specified in subsection (b)(10)(A) and, for the determination of encounter payment rates effective prior to January 1, 2002, subsection (b)(10)(C)); or the number of encounters resulting from the application of the minimum efficiency standards found in subsections (b)(10)(A) and (b)(10)(C); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

C) Supplemental services component.
The supplemental services component is the sum of the following two components:

i) The allowable supplemental cost per encounter, which is the quotient of the cost of services (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling), excepting core services, dental services and, effective January 1, 2002, Behavioral Health Services, provided by the Center, divided by the greater of the number of encounters reported by direct staff; or the number of encounters resulting from application of the

minimum productivity standards found in subsections (b)(10)(A) and (b)(10)(C) of this Section; and

ii) The allowable overhead cost per encounter, which is the product of the allowable supplemental cost per encounter multiplied by the Center's allowable overhead rate factor.

D) Annual cost per encounter.
The annual cost per medical encounter is the sum of the core services component, as determined in subsection (b)(2)(B) of this Section, and the supplemental services component, as determined in subsection (b)(2)(C).

3) Annual Reasonable Cost Per Dental Encounter

A) The annual reasonable cost per dental encounter shall be the lesser of:

i) The annual cost per encounter, as calculated in subsection (b)(3)(B) of this Section; or

ii) The reasonable cost of providing a dental encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) Annual cost per encounter.
The annual cost per encounter is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct dental cost, as defined in subsection (b)(1)(B), divided by the greater of the number of encounters reported by direct dental staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(B); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

4) Annual Reasonable Cost Per Behavioral Health Service Encounter
Effective for services provided on or after January 1, 2002, a separate annual reasonable cost per Behavioral Health Service encounter shall be determined.

A) The annual reasonable cost per Behavioral Health Service encounter shall be the lesser of the following:

i) The annual cost per encounter, as calculated in subsection (b)(4)(B) of this Section.

ii) The reasonable cost of providing a Behavioral Health Service encounter, which shall be 105 percent of the Statewide median of the calculated annual cost per encounter for FQHCs or RHCs, as the case may be.

B) Annual cost per encounter.
The annual cost per encounter is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost for Behavioral Health Services, as defined in subsection (b)(1)(B) of this Section, divided by the greater of the number of encounters reported by direct behavioral health staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(C); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

5) For any individual eligible under the medical assistance programs, a Center may bill only one medical encounter, one dental encounter, and one behavioral health encounter per day. A Center will be reimbursed for a service only if it has enrolled with the Department to provide that service.

6) Claims submitted to the Department must identify all services provided during the encounter.

7) Cost Basis

Each Center must annually complete a cost report, in a format specified by the Department, for the Center's fiscal year. Each FQHC must also annually submit a copy of financial statements audited by an independent Certified Public Accountant. The cost report and audited financial statements must be filed with the Department within 180 days after the close of the Center's fiscal year, except for cost reports and audited financial statements for Center fiscal years 1999 and 2000 which, in the case of FQHCs, must be filed with the Department no later than November 30, 2001, and in the case of RHCs, must be filed no later than March 30, 2002. Except for the first year during which the Center begins operations, the cost report must cover a full fiscal year ending on June 30 or other fiscal year that has been approved by the Department. Payments will be withheld from any Center that has not submitted the cost report by the applicable filing date, and no payments will be made until such time as the reports or audited statements are received and approved by the Department.

8) Establishment of Initial Year Payment Amount for a New Center
For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs with similar caseloads, as determined by the Department. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter Statewide for all FQHCs or RHCs, as the case may be.

9) Rate Adjustments

A) Initial rate determinations.

i) On or about January 1, 2002, the Department shall determine the medical and dental encounter rates for each participating FQHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected FQHC.

ii) On or about January 1, 2003, the Department shall determine the medical and dental encounter rates for each participating RHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted

and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected RHC.

B) Annual adjustment.

i) Beginning January 1, 2002, and annually thereafter, except as specified in subsection (b)(9)(B)(ii) of this Section, the Department will adjust baseline rates by the most recently available MEI. The adjusted rates shall be paid for services provided on or after the date of adjustment.

ii) In the instance of a Center that provided Behavioral Health Services prior to January 1, 2002, for the purpose of applying the January 1, 2002, adjustment by the most recently available MEI, the baseline medical services encounter rate applicable for services provided from January 1, 2001, through December 31, 2001, shall be redetermined after removal of costs and encounters attributable to Behavioral Health Services.

C) Scope of service adjustment.
If a Center significantly changes its scope of services, the Center may request that new baseline encounter rates be determined. Adjustments to encounter rates will be made only if the change in the scope of services results in the inclusion of Behavioral Health Services or dental services or a difference of at least five percent from the Center's current rate. The Department may initiate a rate adjustment, based on audited financial statements or cost reports, if the scope of services has been modified to include Behavioral Health Services or dental services or would otherwise result in a change of at least five percent from the Center's current rate.

10) Reasonable Cost Considerations
The following minimum efficiency standards will be applied to determine reasonable cost:

A) Medical direct care productivity.
The Center must average 4,200 encounters annually per full-time equivalent (FTE) for physicians and 2,100 encounters per FTE for mid-level health care staff (i.e., physician assistants, nurse practitioners, specialized nurse practitioners and nurse midwives).

B) Dental direct care productivity.
The Center must average 1.5 encounters per hour per FTE for dentists.

C) Behavioral health direct care productivity.
The Center must average 2,100 annual encounters per FTE for licensed clinical psychologists, licensed clinical social workers and licensed clinical professional counselors.

D) Guideline for non-physician health care staff.
The maximum ratio of staff is four FTE non-physician health care staff for each FTE staff subject to the direct care productivity standards in subsections (b)(10)(A) and (B) of this Section.

E) Allowable overhead.
The maximum Medicaid allowable overhead cost is 35 percent of allowable total cost.

11) Adjustments for Medical Services Paid for by a Managed Care Organization (MCO)
The Department shall make payment adjustments to a Center if it provides care through a contractual arrangement with a Medicaid MCO and is reimbursed an amount, reported to the Department, that is less than the minimum payment required in 42 USC 1396a(aa). The amount of any such payment adjustment shall be at a fixed annual rate as determined by the Department. For each Center so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the Center (including all payments made on a service-by-service, encounter or capitation basis). In the event that Center cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into consideration other relevant data. Adjustments will be made, at least quarterly, only for Medicaid eligible services. All such services must be defined in a contract between the Center and the MCO. Such contracts must be made available to the Department.

12) Audits
All cost reports will be audited by the Department. The Center will be advised of any adjustment resulting from these audits.

13) Alternate Payment Methodology for Government-Operated Centers

A) A Center operated by a State or local government agency may elect to be reimbursed under the alternate payment methodology described in this subsection (b)(13).

B) The State or local government agency shall enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the Center and the funding of those services.

C) The Center operated by a State or local government agency shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section.

D) The State or local government agency shall certify the expenditure of public funds in excess of reimbursement received from the Department, under subsection (b)(13)(C) of this Section, and any reimbursement from other payers (e.g., an insurance company, a managed care organization) for services provided to individuals eligible for medical assistance programs administered by the Department, provided the funds were not derived from a federal funding source or were not otherwise used as a State or local match for federal funds. The certification shall be in the form and format specified by the Department. The certification shall be filed within 30 days after the submission of the annual cost report. The certification shall compare expenditures within that cost reporting period to payments received or receivable for that same period.

E) The certified expenditures shall be used by the Department to claim federal financial participation. Federal funds resulting from the claiming of the certified expenditures shall be distributed, according to the provisions of the agreement referenced in subsection (b)(13)(B) of this Section, to the State or the government agency that operates the Center that provided the services.

14) Alternate Payment Methodology for Certain Qualifying Centers

A) No later than 30 days after the initial rate determination specified in subsection (b)(9)(A) of this Section, the Department shall determine the eligibility of each Center for this alternative payment

methodology. A Center will qualify for this alternative payment methodology if the Department's estimate of the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the reimbursement policy and rates in effect prior to the initial rate determination, is greater than the total amount that will be paid for those same services under the initial rates. The Department shall notify each qualifying Center, in writing, of the result of this determination.

B) A qualifying Center may, for services provided from January 1, 2002 through December 31, 2002, elect to be reimbursed under the alternate payment methodology described in this subsection (b)(14). A qualifying Center must notify the Department, in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternative payment methodology.

C) A Center electing this alternative payment system shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section, except the medical encounter payment rate shall be increased by an amount equal to twice the quotient resulting from the Department's estimate of the difference between the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the initial rates as determined in subsection (b)(9)(A); and the total amount that would have been paid under the payment rates in effect prior to the initial rate determination, divided by the Department's estimate of total medical encounters during the 12-month period ending December 31, 2001.

15) Alternate Behavioral Health Payment Methodology for Certain Qualifying Centers
Centers that are certified by the Department of Human Services-Division of Mental Health, or the Department of Children and Family Services to provide Behavioral Health Services may elect an alternate payment methodology for their Behavioral Health Services. An election of this alternate payment methodology will allow the Centers to be reimbursed under the provisions of 59 Ill. Adm. Code 132 for Behavioral Health Services provided. A qualifying Center must notify the Department in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternate

payment methodology.

16) All service sites operated by a Center shall be reimbursed using the Center's established encounter rates, except in the instance where the site submitted separate cost reports and separate baseline rates were determined for the site.

c) Rate Appeals Process

1) All appeals of audit adjustments or rate determinations must be submitted in writing to the Department. Appeals must be submitted within 60 calendar days after the notification of such adjustments or rate determinations. If upheld, the revised audit adjustment or rate determination shall be made effective as of the beginning of the rate period.

2) To be accepted for review, the written appeal shall include the following:

A) The current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal.

B) A clear, concise statement of the basis for the appeal.

C) A detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement.

D) A statement by the Center's chief executive officer or financial officer that the application of the rate appeal and information contained in the Center's reports, schedules, budgets, books, and records submitted are true and accurate.

3) Rate appeals may be considered for the following reasons:

A) Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable costs.

B) Mechanical or clerical errors committed by the Department in auditing historical expenses as reported and/or in calculating reimbursement rates.

4) The Department shall rule on all appeals within 120 calendar days after receipt of the complete appeal, except that, if additional information is required from the facility, the period shall be extended until such time as the information is provided.

5) Appeals shall be submitted to the Department's Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763-0002.

(Source: Amended at 31 Ill. Reg. 14749, effective October 22, 2007)

Section 140.464 Hospital-Based and Encounter Rate Clinic Payments

a) Hospital-Based Organized Clinics

1) With respect to those hospital-based organized clinics, as described at Section 140.461(a), that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), payment shall be in accordance with Section 140.930.

2) With respect to all other hospital-based organized clinics, payment shall be in accordance with 89 Ill. Adm. Code 148.140.

b) Encounter Rate Clinics

1) For encounter rate clinics, as described at Section 140.461(b), providing comprehensive health care for infants and women, including but not limited to prenatal and postnatal care, payment shall be made at the lesser of:

A) $90 per encounter; or

B) The clinic's charge to the general public.

2) For encounter rate clinics, as described at Section 140.461(b), providing dental services, payment shall be made at the lesser of:

A) $85 per encounter; or

B) The clinic's historical annual cost per encounter as calculated for a Federally Qualified Health Center (FQHC) in accordance with Section 140.463(b)(3)(B).

3) For all other encounter rate clinics, payment shall be made at the lesser of:

A) The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

B) $50 per encounter; or

C) The clinic's charge to the general public.

(Source: Amended at 35 Ill. Reg. 7962, effective May 1, 2011)

Section 140.465 Speech and Hearing Clinics (Repealed)

(Source: Repealed at 15 Ill. Reg. 17318, effective November 18, 1991)

Section 140.466 Rural Health Clinics (Repealed)

(Source: Repealed at 26 Ill. Reg. 4781, effective March 15, 2002)

Section 140.467 Independent Clinics

a) Payment for all other Medicaid covered services provided by an independent clinic will be made on a fee-for-service basis, that is, the lower of charges or the Department's established maximum for the service, not to exceed the lowest Medicare reimbursement levels.

b) Payments to independent clinics will be subject to a two-way reconciliation of payments to reasonable costs.

(Source: Amended at 23 Ill. Reg. 7122, effective June 1, 1999)

Section 140.469 Hospice

a) Hospice is a continuum of palliative and supportive care, directed and coordinated by a team of professionals and volunteer workers who provide care to terminally ill persons to:

1) reduce or abate pain or other symptoms of mental or physical distress, and

2) meet the special needs arising out of the stresses of terminal illness, dying or bereavement.

b) Hospice care is a covered service for all eligible clients, including residents of intermediate and skilled care facilities, when provided by a Medicare certified hospice provider and in accordance with provisions contained in section 1902(a)(13)(B) of the Social Security Act (42 USC 1396a(a)(13)(B)).

c) Covered services include:

1) Nursing care,

2) Physician services,

3) Medical social services,

4) Short term inpatient care,

5) Medical appliances, supplies and drugs,

6) Home health aide services,

7) Occupational, physical and speech-language therapy services to control symptoms, and

8) Counseling services.

d) Reimbursement shall be at the established Medicare rate for the specific level of care into which each day of care is classified. The four levels of care are:

1) Routine Home Care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given

day.

2) Continuous Home Care. The continuous home care rate will be paid when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

3) Inpatient Respite Care. The inpatient rate will be paid each day on which the beneficiary is in the approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth day and any subsequent days is to be made at the routine home care rate.

4) General Inpatient Care. The inpatient rate will be paid when general inpatient care is provided. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives hospice inpatient care except for the day of discharge from an inpatient unit. In which case, the appropriate home care rate is to be paid unless the patient dies as an inpatient.

e) When the individual resides in an ICF or SNF facility, the Department shall provide payment of an add-on amount to the hospice on routine home care and continuous home care days. The add-on amount will constitute a portion of the facility rate the State would be responsible for as mandated by 42 CFR 418.1-418.205. The add-on amount for county-owned/operated nursing facilities shall be based on the rates established pursuant to Section 140.530(c)(1).

f) The hospice shall receive an add-on amount for other physician services such as direct patient care when physician services are provided by an employee of the hospice or under arrangements made by the hospice unless those services are performed on a volunteer basis. These add-on amounts will be utilized when determining the hospice cap amount.

g) Medicaid payment to a hospice provider for care furnished over the period of a year shall be limited by a payment cap as set forth in 42 CFR 418.309. Any overpayment shall be refunded by the hospice provider.

(Source: Amended at 31 Ill. Reg. 5561, effective March 30, 2007)

Section 140.470 Eligible Home Health Providers

The Department will reimburse the following as home health care providers:

a) A Medicare-certified home health agency;

b) A home health agency certified by the Department of Public Health as Medicare certifiable or as meeting the requirements of Medicare;

c) A self-employed nurse who is licensed as a registered nurse as defined by the Nursing and Advanced Practice Nursing Act [225 ILCS 65], when there is no home health agency in the area available to provide needed services;

d) A health department certified by the Department of Public Health;

e) A community health agency; or

f) A nursing agency approved by the University of Illinois at Chicago, Division of Specialized Care for Children to provide services for children and adolescents under 21 years of age.

(Source: Amended at 29 Ill. Reg. 14957, effective September 30, 2005)

Section 140.471 Description of Home Health Services

a) Home health services are services provided for participants in their places of residence and are aimed at facilitating the transition from a more acute level of care to the home.

b) Services provided shall be of a curative or rehabilitative nature and demonstrate progress toward goals outlined in a plan of care. Services shall be provided for individuals upon direct order of a physician and in accordance with a plan of care established by the physician and reviewed at least every 60 days.

c) For purposes of this Section, "residence" does not include a hospital, a skilled nursing facility, an intermediate care facility, or a supportive living facility. The term "residence" includes an intermediate care facility for the mentally retarded only to the extent that home health services are not required to be provided under 89 Ill. Adm. Code 144.

(Source: Amended at 29 Ill. Reg. 14957, effective September 30, 2005)

Section 140.472 Types of Home Health Services

The types of services for which payment can be made are:

a) Intermittent skilled nursing in the home for the purpose of completing an assessment, evaluation or administration.

b) Shift nursing care in the home for the purpose of caring for a participant under 21 years of age who has extensive medical needs and requires ongoing skilled nursing care.

c) Home Health Aid.

d) Speech Therapy.

e) Occupational Therapy.

f) Physical Therapy.

(Source: Amended at 29 Ill. Reg. 14957, effective September 30, 2005)

Section 140.473 Prior Approval for Home Health Services

a) Prior approval is required for the provision of home health services described in Section 140.472. The decision to approve or deny a request for prior approval will be made within 21 days after the date the request is received or within 21 days after receipt of additional information, whichever occurs later. Prior approval is also required for participants needing more than one skilled nursing visit per day.

b) Prior approval is required for the provision of all home health services to terminally ill participants covered under the Transitional Assistance Program and the Family and Children Assistance Program.

c) Prior approval is not required for the first 60 days of service provided by a home health agency provider for participants discharged from an acute care or rehabilitation hospital when services are initiated within 14 days after discharge.

d) Prior approval is required for all in-home shift nursing for children under 21 years of age. The decision to approve or deny a request for prior approval will be made within 21 days after the date the request is received or within 21 days after receipt of additional information, whichever occurs later. Review of services for children eligible for in-home shift nursing under the Illinois Home and Community-Based Services Waiver for Medically Fragile, Technology Dependent Children, will be made in accordance with 89 Ill. Adm. Code 120.530.

e) Approval will be granted when, in the judgment of a consulting physician and subject to the review of the professional staff of the Department, the services are medically necessary and appropriate to meet the participant's medical needs.

(Source: Amended at 29 Ill. Reg. 14957, effective September 30, 2005)

Section 140.474 Payment for Home Health Services

a) Except for subsections (b) and (c) of this Section, home health agencies shall be paid an all inclusive, per visit rate which shall be the lowest of:

1) the agency's usual and customary charge for the service;

2) the agency's Medicare rate; or

3) the Department's maximum allowable rate of $65.25. Beginning with the State fiscal year 2002, the maximum allowable rate may be adjusted annually in consideration of the appropriation of funds by the General Assembly.

b) Payment to self-employed registered nurses providing in-home nursing services is made at the community rate for such services as determined for each case at the time prior approval is given.

c) Payment for in-home shift nursing for children under 21 years of age under Section 140.472(b) shall be at the Department's established hourly rate. The hourly rate for in-home shift nursing care may be adjusted in consideration of the appropriation of funds by the General Assembly.

(Source: Amended at 29 Ill. Reg. 14957, effective September 30, 2005)

Section 140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices

a) Payment for the provision of medical equipment, supplies, prosthetic devices and orthotic devices shall be made only to participating providers who are licensed or exempt from licensure under any licensure Act, including but not limited to the Home Medical Equipment and Services Provider License Act [225 ILCS 51].

b) Payment for medical equipment, supplies, prosthetic devices and orthotic devices shall be made:

1) when:

A) they are essential to enable a client to remain at home or to function in the community; and

B) the client's physician has recommended in writing to the Department or in a patient care plan that the supplies or equipment be provided and that they are medically necessary; and

C) the Department has approved payment based on consideration of:

i) the client's medical condition,

ii) the benefits the item is expected to effect,

iii) the client's ability to adjust to and to use the item recommended, and

iv) in the case of a communication device, whether the device will increase the client's potential for full participation in health care by assisting in cause and effect awareness, or training physical movements or improving the client's understanding and comprehension of his or her health needs and responsibilities; or

2) when the Individual Program Plan (IPP) of an individual with developmental disabilities residing in an ICF/MR or a long term care facility identifies the equipment, supplies, prosthetic devices and orthotic devices that are necessary for his or her participation in active treatment as described in 42 CFR 483.440, Condition of Participation: Active Treatment Service.

c) Payment shall be made for the repair of prosthetic devices, orthotic devices and medical equipment owned by recipients if the item is out of warranty and the sum of the individual repair parts and the labor does not exceed 75 percent of the cost of a new unit. Labor charges are to be included in the repair price. A guarantee of at least 180 days must be provided. Charges shall not include tax, delivery, rebate, packaging or freight. The Department may agree to assume repair costs of a rented or loaned communication system if such an agreement is required by the manufacturer's or vendor's rental or loan terms. The Department may deny payment for repairs if evidence indicates that damage has resulted from abuse of the equipment.

d) Payment shall be made for loaner items issued pending repair or replacement of prosthetic devices, orthotic devices and medical equipment owned by recipients if it is the usual practice of the supplier to provide and charge for such items.

e) Covered services are:

1) Non-durable medical supplies for an individual's life maintenance care and treatment;

2) Durable medical equipment essential to expedite a hospital discharge and to enable the person to be cared for at home;

3) Prosthetic and orthotic devices, including communication devices, that are essential to enhance functional mobility or medically necessary communication or are essential for employment;

4) Respiratory equipment and supplies necessary as a life saving measure or for prevention of a medical emergency, institutionalization, or to facilitate deinstitutionalization; and

5) Repair of durable medical equipment, prosthetic devices and orthotic devices.

f) Payment shall be made for covered services on a prior approval basis, except as provided under Section 140.477.

(Source: Amended at 25 Ill. Reg. 12820, effective October 8, 2001)

Section 140.476 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices for Which Payment Will Not Be Made

Payment shall not be made for:

a) Items or repair of items for residents of long term care facilities, when such items are:

1) Durable medical equipment or supplies required by an individual in a long term care facility that are commonly used in patient care and considered as a part of the per diem reimbursement paid by the Department. Such items include, but are not limited to the following:

A) Equipment: Canes, crutches, standard wheelchairs, walkers, commodes, beds, mattresses, belts, cradles, trapeze bars, patient lifts, bedpans, urinals, suction equipment, supplies, hypothermia units, apnea monitors, and equipment necessary for the administration of oxygen.

B) Supplies: Catheters, urinary drainage bags, first aid supplies, dressings, soaps, irrigation supplies, drinking tubes, and other supplies necessary to provide patient care.

2) Equipment required for a resident of a long term care facility, unless the equipment must be made to order for an identified recipient and based on a medical need, or which is identified by the Individual Program Plan (IPP) of an individual with developmental disabilities as necessary to fulfill the requirements for active treatment services.

b) Items or services that are not medically necessary to treat the recipient's disease, disability, infirmity or impairment.

c) Prosthetic and orthotic devices inserted or implanted that do not increase physical capacity, overcome a handicap, restore a physiological function, or eliminate a functional disability.

d) Items or services for which the Department has not granted prior approval where prior approval is required.

e) Stock orthopedic shoes, unless used in conjunction with a brace.

f) Items or services for a client who has elected hospice care, when the items or

services are related to the terminal illness.

g) Items or services fabricated, fitted or dispensed without an appropriate license.

(Source: Amended at 25 Ill. Reg. 12820, effective October 8, 2001)

Section 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices

a) Prior approval for the purchase, repair or rental of certain medical equipment, prosthetic devices and orthotic devices is required except when:

1) The client is a Medicare beneficiary and the item requested has been reimbursed under the Medicare program; or

2) Repair costs do not exceed 75 percent of the purchase price and the item is not covered by a warranty; or

3) The item is being loaned pending repair or replacement of the recipient's own item.

b) Replacement of covered equipment, prosthetic devices and orthotic devices is subject to all policies that apply to an original purchase of the same item. Replacements will not be reimbursed by the Department if the original item is under a warranty that would cover the necessary repairs or replacement. If the item requires prior approval and if the item was purchased by the Department for the same client within the past 12 months, the Department's original determination of medical necessity will be deemed adequate for the replacement purchase. In this case, the request for prior approval must contain an explanation of the need for replacement. The Department may deny payment for replacement of equipment if evidence indicates that breakage or loss has resulted from abuse of the equipment.

(Source: Amended at 25 Ill. Reg. 12820, effective October 8, 2001)

Section 140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices

a) The following time frames shall be adhered to by the Department when prior approval is required for medical equipment, prosthetic devices and orthotic devices (see also Section 140.40):

1) Decisions to approve or deny a request for prior approval of life-sustaining respiratory supplies and equipment will be made within 30 days after the date of receipt of the request by the Department. Prior approval is not required for such items for the first 30 days of service.

2) Decisions to approve or deny requests for artificial limbs and braces shall be made within 21 days after the date of receipt of the request by the Department.

3) Decisions to approve or deny requests for standard wheelchairs and hospital beds shall be made within 21 days after the date of receipt of the request by the Department.

4) Decisions to approve or deny requests for hearing aids, communication devices, custom molded shoes, shoe corrections, orthopedic shoes used in conjunction with a brace, and custom wheelchairs, shall be made within 30 days after the date of receipt of the request by the Department.

5) Decisions to approve or deny requests for medical supplies costing less than $100 shall be made within 21 days after the date of receipt of the requests by the Department.

6) Decisions to approve or deny requests for medical supplies costing more than $100 shall be made within 30 days after the date of receipt of the request by the Department.

b) Post approval may be requested. Post approval will be granted in circumstances when prior approval could not be requested, such as:

1) determination of the patient's eligibility for public assistance was delayed;

2) the medical need arose unexpectedly outside of the Department's normal business hours and prior approval could not be obtained;

3) other third party resources denied payment.

(Source: Amended at 25 Ill. Reg. 12820, effective October 8, 2001)

Section 140.479 Limitations, Medical Supplies

a) Reimbursement for medical supplies will be limited to the quantity indicated by the ordering practitioner or to the quantity specified in the Department's prior approval, whichever is less. Once the total quantity specified by the ordering practitioner has been provided or the period of time shown on the approval request has elapsed, a new written order must be obtained.

b) A new written order must be obtained from the physician no less often than every 12 months, even for supplies needed for an ongoing chronic condition.

c) Prior approval for the purchase of medical supplies is required except when:

1) The client is a Medicare beneficiary and the item requested has been reimbursed under the Medicare program; or

2) Items are being dispensed, per physician order, in amounts less than the normal maximum allowable quantity limits established by the Department.

d) The exemptions from prior approval specified in subsection (c) apply only if the quantity ordered by the physician is equal to or less than the Department's maximum allowable quantity. If the physician has ordered a quantity that exceeds the Department's maximum allowable quantity, the dispensing provider must request prior approval for the entire order. The Department will not pay for the dispensing of any quantity that is less than the physician's order, unless:

1) the dispensing provider can document that the ordering physician has confirmed that the excess quantity is not medically necessary; or

2) the Department has denied the request for prior approval of the excess quantity.

(Source: Amended at 25 Ill. Reg. 12820, effective October 8, 2001)

Section 140.480 Equipment Rental Limitations

Total cumulative rental costs must not exceed the usual retail price of the medical equipment except for durable equipment used for respiratory care. When total cumulative rental costs exceed the purchase price, the Department considers the equipment paid for in full and the property of the Department. Some durable medical equipment items used for respiratory care are covered on a rental or lease basis only. Rental charges must be terminated after the recipient's need for the equipment ceases to exist.

(Source: Amended at 25 Ill. Reg. 12820, effective October 8, 2001)

Section 140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids

a) Notwithstanding the provisions set forth in this Section, beginning July 1, 2002, the reimbursement rates paid for medical equipment, supplies, prosthetic devices and hearing aids shall be the lesser of the provider's usual and customary charge to the general public or 94 percent of the fiscal year 2002 rate otherwise determined by the Department under this Section.

b) Payment for Medical Equipment. Medical equipment is durable, reusable equipment such as wheelchairs, hospital beds, canes, walkers, etc. Payment for medical equipment is made for covered items or services at the lesser of the provider's charge or the maximum allowable rate established by the Department. The maximum allowable rate established by the Department for each item of medical equipment is to be based on pricing for widely accepted quality items. The Department shall review and update the maximum allowable rate at least annually. Widely accepted quality items are items which are not below average quality for like medical equipment and which are available statewide. The maximum allowable rate established for each item or service shall be the least of:

1) The average suggested retail price derived from available medical supply catalogs and/or providers' price lists; or

2) The wholesale price derived from available medical supply catalogs and/or providers' price lists for each item plus 50 percent; or

3) The Medicare allowable rate for covered Medicare items or services.

c) Medical supplies are medical items which are not durable or reusable such as surgical dressings, disposable syringes, catheters, urinary bags, etc. Payment for medical supplies is made for covered items at the lesser of the provider's charge or the maximum allowable rate established by the Department. The maximum allowable rate for each item of medical supplies shall be based on pricing for widely accepted quality items as defined in subsection (b) of this Section. The Department shall review and update the maximum allowable rate at least annually. The maximum allowable rate established for each item shall be the least of:

1) The average suggested retail price derived from available medical supply catalogs and/or providers' price lists; or

2) The wholesale price derived from available medical supply catalogs

and/or providers' price lists for each item plus 50 percent; or

3) The Medicare allowable rate for covered Medicare items or services.

d) Payment for Prosthetic and Orthotic Devices. Prosthetic and orthotic devices include 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. Payment for prosthetic and orthotic devices is made for covered items or services at the lesser of the provider's charge or the maximum allowable rate established by the Department. The maximum allowable rate for each item of prosthetic and orthotic devices shall be based on pricing for widely accepted quality items as defined in subsection (b) of this Section. The Department shall review and update the maximum allowable rate at least annually. The maximum allowable rate established for each item shall be the least of:

1) The average suggested retail price derived from available medical supply catalogs and/or providers' price lists; or

2) The wholesale price derived from available medical supply catalogs and/or providers' price lists for each item plus 50 percent; or

3) The Medicare allowable rate for covered Medicare items or services.

e) Payment for hearing aids shall be made at the lesser of the provider's charge or the maximum allowable rate established by the Department. The hearing aid shall be priced by the Department at the vendor's actual acquisition cost, without exceeding the Department's upper limits of reimbursement for the item. Acquisition cost is defined as the actual amount the supplying provider pays for the hearing aid(s). Any discounts, rebates or bonuses shall be subtracted when calculating the acquisition cost. The amount of any rebates or bonuses shall be prorated on all purchases for which the rebate or bonus was earned. The prorated share shall be subtracted when calculating the acquisition cost of the item. Verification of the vendor's acquisition cost must be attached to the request for reimbursement. In addition to payment for the acquisition costs, the Department will pay a dispensing fee. Payment for a dispensing fee shall include reimbursement for fitting, follow-up visits, shipping and retail mark-up. The Department shall review and update the maximum allowable rate at least annually.

1) To establish the maximum limit for the acquisition cost of the hearing aid, the Department shall review wholesale prices from available supply

catalogs and provider price lists for the most widely accepted brands and types of technology.

2) To establish the maximum allowable rate for the dispensing fee, the Department shall use an average of available rates charged by audiologists for three hearing aid follow-up visits, not to exceed the Department's maximum allowable rate for a physician visit of low complexity for an established patient, plus the average of available shipping fees charged by the wholesaler for hearing aid shipping and an amount for the retail mark-up, determined by taking 50 percent of the average wholesale price of the hearing aids reviewed.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.482 Family Planning Services

a) Payment shall be made for the provision of Family Planning services only to providers who are enrolled to participate in the Medical Assistance Program.

b) Family Planning services consisting of contraceptive devices and birth control methods shall be available without regard to age, sex or marital status.

c) Payment shall be made for preliminary physician examinations, annual examinations, professional services when problems are indicated, laboratory tests, contraceptive devices, supplies and surgical sterilization procedures.

Section 140.483 Limitations on Family Planning Services

Payment for sterilization procedures shall be made only under the following conditions:

a) When informed consent as defined under Federal regulations for the Medicaid program (42 CFR 441.250 – 44l.259) is given and a consent form acceptable under Federal regulations is properly signed and witnessed by the patient, a witness, and the surgeon not less than 30 days or more than l80 days or in cases of premature delivery or emergency abdominal surgery not less than 72 hours prior to completion of the surgical procedure. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

b) The patient must have attained the age 2l years.

c) The patient must be mentally competent to render consent for sterilization procedure.

Section 140.484 Payment for Family Planning Services

Payment for the specific service or procedure provided shall be made at the usual and customary charge, not to exceed the rates or fees established under the provision of the Department reimbursement schedule, pursuant to the Department's Section 140.400. The reimbursement schedule may be obtained by contacting the Bureau of Provider Services, Illinois Department of Public Aid, 93l East Washington, Springfield, Illinois.

Section 140.485 Healthy Kids Program

a) Program Description

1) The Healthy Kids Program is the Early and Periodic Screening, Diagnosis and Treatment Program mandated by the Social Security Act (see 42 U.S.C. 1396a(43), 1396d(4)(B) (Supp.1987)). The goals of the program are to:

A) improve the health status of Medicaid-eligible children ages birth through 20 years through the provision of preventive medical care and early diagnosis and treatment of conditions threatening the child's health; and

B) reduce the long term costs of medical care to eligible children.

2) The Department strives to achieve these goals by offering the following services at no cost to an eligible child, except as may be limited by a spend down requirement:

A) periodic and interperiodic health, vision, hearing and dental screening services to meet the health care needs of children (see Section 140.488(a) through (d));

B) immunizations against childhood diseases (see Section 140.488(e));

C) diagnostic laboratory procedures as described in Section 140.488(f);

D) further diagnosis or treatment necessary to correct or ameliorate defects and physical or mental illnesses or conditions which are discovered or determined to have increased in severity by a provider as the result of a periodic or interperiodic health, vision, hearing or dental screening;

E) referral for dental care beginning at age two; and

F) assistance in locating a provider, scheduling an appointment and in arranging transportation to and from the source of medical care.

3) The Department also strives to protect each eligible person's right to freedom of choice regarding participation and selection of a health care provider and the right to continuity of care.

b) Eligibility. Services are available to those persons listed in Section 140.3, except that such persons must be under 21 years of age at the time of receiving such services.

c) Provider Participation. Providers of Healthy Kids services must be duly licensed or certified according to applicable Federal or State law or rule and be enrolled in the Illinois Medical Assistance Program to provide one or more Healthy Kids Program services as authorized in Title XIX of the Social Security Act and the Illinois Medical Assistance Program State Plan (as set forth in Sections 140.11 thru 140.835).

d) Program Activities and Services

1) Informing Clients. The Department shall inform eligible persons in writing about the benefits of preventive health care, the services which are available, and procedures by which eligible persons may request and receive assistance in identifying an enrolled provider, scheduling an appointment or arranging transportation to and from the source of medical care. Effective July 1, 1990, the Department shall also notify Medicaid-eligible pregnant women, postpartum women during the six months after termination of pregnancy, women up to one year postpartum who are breastfeeding their infants or children below the age of five years of their potential eligibility for receiving services through the Special Supplemental Food Program for Women, Infants and Children which is administered by the Illinois Department of Public Health (IDPH). The informing of eligible persons shall be done as described in the Timeliness Standards contained in Section 140.487.

2) Periodic Medical Screenings. The Department will pay for a series of periodic medical screenings scheduled from a person's birth through age 20. The Periodicity Schedule of screenings is contained in Section 140.488. The Department will pay for additional health screenings when necessary for:

A) enrollment in school; or

B) enrollment in a licensed day care program, including Headstart; or

C) placement in a licensed child welfare facility, including a foster home, group home or child care institution; or

D) attendance at a camping program; or

E) participation in an organized athletic program; or

F) enrollment in an early childhood education program recognized by the Illinois State Board of Education, or

G) participation in a Women, Infant and Children (WIC) program; or

H) is requested by a child's parent, guardian or custodian, or is determined to be necessary by social services, developmental, health, or educational personnel.

3) Dental Screenings

A) Dental services shall include services for relief of pain and infections, restoration of teeth, and maintenance of dental health, including instruction in self-care oral hygiene procedures.

B) Eligible persons shall be referred for dental screenings beginning at age two if the person is not in the continuing care of an enrolled dental provider, except that a child younger than age two years may be referred for dental services when any health screening indicates the need for dental services.

C) The periodicity schedule for dental screening services is contained in Section 140.488. The Department will pay for one dental screening per age period unless a second screening is medically necessary.

4) Vision Screening

A) The Department will pay for vision screening services, and diagnosis and treatment for defects in vision, including glasses.

B) The periodicity schedule for vision screenings is contained in Section 140.488. The Department will pay for one vision screening per age period, except when a second screening is determined to be medically necessary.

5) Hearing Screening. The Department will pay for hearing screenings and diagnosis and treatment for defects in hearing, including hearing aids. The periodicity schedule for hearing screenings is contained in Section 140.488. The Department will pay for one hearing screening per age period, except when a second screening is determined to be medically necessary.

6) Immunizations. The Department will pay for the immunization of eligible children against childhood diseases. The list of covered immunizations is contained in Section 140.488(b).

7) Diagnostic Procedures

A) Lead Screening

i) The Department requires that lead screening shall be performed in compliance with the "Lead Poisoning Prevention Act, Public Act 87-175", as amended, effective January 1, 1992. Children between the ages of six months to six years should be screened for lead poisoning at priority intervals. Screenings and medical follow up shall be performed in accordance with the "Guidelines for the Detection and Management of Lead Poisoning for Physicians and Health Care Providers", published by the Illinois Department of Public Health. These guidelines recommend that those children at highest risk be screened on a regular basis. High risk environmental situations include ho using built before 1978, housing which is being renovated or remodeled, or which is in deteriorating condition. Children six years and older shall also be screened, where medically indicated or appropriate.

ii) The Department will pay for lead screening as indicated in subsection (d)(7)(A)(i) above or as required for admission by a day care center, day care home, preschool, nursery school, kindergarten, or other child care facility or educational facility licensed by the State.

iii) The Department will pay for epidemiological study of the child's living environment when the child has been diagnosed as having an elevated blood lead level for the

purpose of identifying the source of lead exposure.

B) The Department will pay for the administration of all other medically necessary diagnostic procedures performed during or as the result of medical screenings.

8) Treatment. The Department shall pay for necessary medical care (see Section 140.2), diagnostic services, treatment or other measures medically necessary (e.g., medical equipment and supplies) to correct or ameliorate defects, and physical and mental illnesses and conditions which are discovered or determined to have increased in severity by medical, vision, hearing or dental screening services.

9) Assistance Services. The Department shall, upon request, provide assistance to eligible children and their parent, guardian or custodian to locate a provider, schedule an appointment or arrange transportation to and from the source of medical care.

10) Timeliness Standards. The Timeliness Standards in Section 140.487 will govern the completion of required activities and services.

e) Reimbursement to Providers

1) Fee-for-service. Provider's enrolled in the Maternal and Child Health Program, as described in Subpart G, will receive enhanced rates for certain services, as described in Section 140.930(a)(1). Payment will be made at the provider's usual and customary charges or the established Department rate(s) (see Section 140.400), whichever is less, for providers not enrolled in the Maternal and Child Health Program. Reimbursement for the administration of immunizations to an eligible person will be made at rates established by the Department. The provider will receive replacement vaccines as explained in subsection (e)(3) below.

2) Claims. Claims for reimbursement shall be submitted on the form and in a manner specified by the Department.

3) Vaccine Replacement Program. When a provider administers an immunization to an eligible child, the vaccines are replaced to the provider through the Vaccine Replacement Program which is administered jointly by the Department and the IDPH. Providers must be annually certified for participation in the Vaccine Replacement Program by IDPH before receiving replacement vaccines. Information on the Vaccine Replacement

Program and certification procedures (set forth at 42 CFR 51b) may be obtained by contacting:

Immunization Vaccine Replacement Program
Illinois Department of Public Health
525 West Jefferson Street
Springfield, Illinois 62761

f) Limitations on Services. Services under the Healthy Kids Program shall only be available to persons in the age groups from birth through age 20. Coverage of and payments for services shall be consistent with the requirements of Section 1905 of the Social Security Act (42 U.S.C. 1396d) as it relates to the Early and Periodic Screening, Diagnosis and Treatment Program.

g) Record Requirements. The provider shall comply with record requirements as set forth in Section 140.28.

(Source: Amended at 20 Ill. Reg. 4345, effective March 4, 1996)

Section 140.486 Illinois Healthy Women

a) Benefit coverage under Illinois Healthy Women is available to women meeting the eligibility requirements set forth in 89 Ill. Adm. Code 120.540.

b) Covered medical services under Illinois Healthy Women are limited to the following reproductive health and family planning services:

1) Physical examination and health history for family planning purposes;

2) Brief and intermediate follow-up office visits related to family planning;

3) Pap smears, at least annually, or as medically indicated;

4) Necessary family planning or women's health related lab and diagnostic tests;

5) Birth control drugs and devices, including the inserting, implanting or injecting of a birth control drug and removing of a birth control device;

6) Sterilization services, pursuant to Section 140.483;

7) Testing and treatment for sexually transmitted infections (STIs) diagnosed during a family planning visit;

8) Testing for HIV, when ordered by a physician during a family planning visit;

9) Generic prenatal vitamins, or generic multi-vitamins with folic acid, or folic acid; and

10) Mammograms, when ordered by a physician during a family planning visit.

c) Payment of services under this Section shall be made to participating providers in accordance with this Part.

(Source: Old Section repealed at 15 Ill. Reg. 298, effective December 28, 1990; new Section added at 28 Ill. Reg. 11161, effective August 1, 2004)

Section 140.487 Healthy Kids Program Timeliness Standards

These timeliness standards for required Healthy Kids services or activities apply regardless of the source from which medical or dental care is provided.

a) Activity 1: Informing Eligible Families

1) Description:
The Department shall inform eligible families in writing about the Healthy Kids Program, including: the importance of preventive health care; the services which are available; how to request assistance in identifying a willing and qualified provider or how to request assistance in obtaining transportation to and from health care appointments; and that the services are available at no cost to an eligible recipient, except as may be limited by a spenddown requirement.

2) Timeliness Standards:

A) At the time of application for public assistance, the applicant will be informed orally by the intake worker and in writing.

B) An applicant determined to be eligible for benefits shall be informed by mail within sixty (60) calendar days of the date of the determination of eligibility for Medicaid services.

C) All eligible persons shall be informed annually by mail.

b) Activity 2: Notification of Scheduled Health, Vision, Hearing and Dental Screening Periods

1) Description:
Eligible persons shall be notified in writing of scheduled health, vision, hearing and dental screening periods.

2) Timeliness Standard:
The child or the caretaker relative (see 89 Ill. Adm. Code 101.20) shall receive notification of the next scheduled health, vision, hearing and dental screening periods not less than 10 working days before the date on which the screening period begins as determined by the child's birthday, the Periodicity Schedule and the most recent date of the child's eligibility for services.

c) Activity 3: Administration of a Health, Vision, Hearing, or Dental Screening

1) Description:
A health, vision, hearing or dental screening shall be performed by a provider who is enrolled with the Illinois Medical Assistance Program.

2) Timeliness Standard:
A health, vision, hearing or dental screening shall occur, to the extent possible, during the next scheduled screening period as determined by the child's birthday, the most recent date of the child's eligibility and the periodicity schedules for screenings.

d) Activity 4: Diagnosis

1) Description:
Diagnosis is the provider's assessment of a child's current state of health or disease.

2) Timeliness Standards:

A) The diagnosis shall be made at the conclusion of the screening, except that the diagnosis may be deferred until the provider receives the results of laboratory tests when such tests are required to establish the diagnosis.

B) The provider shall orally inform the adult responsible for the child of the diagnosis immediately or within 24 hours, unless prohibited by confidentiality rules. In such cases, the provider shall inform the child of the diagnosis within 24 hours and inform the responsible adult only with the child's written consent.

C) If the provider suspects that a child has been abused or neglected as defined in the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. 1989, ch. 23 pars. 2051 thru 2061.7), the provider shall immediately make a report to the Illinois Department of Children and Family Services.

e) Activity 5: Referral for Treatment

1) Description: When a provider determines that a child is in need of treatment for a condition discovered or determined to have increased in severity during a screening, the provider shall arrange to provide the

needed treatment directly or shall refer the client for treatment. Referral for treatment shall include one or more of the following actions: informing the client (or client's caretaker) of the type of provider from whom treatment should be sought; or providing the client (or client's caretaker) with the name and address of a provider qualified to provide the needed treatment; or making an appointment for the client with a provider qualified to provide the needed treatment.

2) Upon request of an eligible person or notification by a qualified provider of an eligible person's need for referral assistance as the result of a screening, the Department shall refer the eligible person to a willing and qualified provider for treatment of a diagnosed or suspected condition, whether or not the treatment needed is a covered service. The eligible person shall be consulted about the referral, except when such consultation may jeopardize the health and safety of the child (e.g., cases of suspected child abuse or neglect). In making the referral, the Department shall first consider referral of the eligible person to other Federal and State-funded programs (e.g., services to crippled children and alcohol/drug abuse intervention) when such programs may be capable of treating or arranging treatment for the condition.

3) Timeliness Standard:
Referral, as defined above, shall be made within thirty (30) days of the request or identification of need, except that such referral shall be made immediately when the child is in imminent danger.

f) Activity 6: Treatment

1) Description:
Treatment is the provision of health care needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered or determined to have increased in severity by a qualified provider as the result of a screening.

2) Timeliness Standard:
Treatment consistent with recognized standards of medical or dental practice shall begin no more than sixty (60) days after the diagnosis of the child's condition, unless medically contraindicated, except that treatment shall begin sooner when the diagnosed condition requires it.

g) Activity 7: Scheduling and Transportation Assistance

1) Description:
Upon oral or written request of a recipient, the Department shall provide assistance to identify a provider, to schedule an appointment with a provider or to arrange transportation to and from the source of medical or dental care.

2) Timeliness Standards:

A) The Department shall determine the recipient's need for the requested assistance within ten (10) working days of the request.

B) The Department shall arrange or provide the needed assistance in time to assure that the recipient receives services within the periodicity schedule or the treatment timeliness standard (see Section 140.488).

h) Activity 8: Coordination with the Women, Infant and Children (WIC) Special Supplemental Food Program

1) Description:
The Department shall inform Medicaid-eligible pregnant women, postpartum women during the six (6) months after termination of their pregnancy, women up to one (1) year postpartum who are breastfeeding their infants and children below the age of five (5) years in writing of the availability of WIC Program benefits and procedures for accessing WIC services.

2) Timeliness Standards

A) The Department shall in writing inform individuals found eligible for Medicaid services and who are also eligible for WIC Program services of the availability of WIC Program benefits and procedures for accessing such services within sixty (60) days of such persons being determined eligible for Medicaid services.

B) The Department shall also annually notify such persons in writing of the availability of WIC Program benefits and procedures for accessing such services.

(Source: Amended at 15 Ill. Reg. 298, effective December 28, 1990)

Section 140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures

a) Health Screening Periodicity Schedule. Eligible clients may receive one periodic health screening during each of the following time periods, except a second screening may be given as explained in Section 140.485(d)(2):

1) Birth to two weeks;

2) two weeks to one month;

3) one to two months;

4) two to four months;

5) four to six months;

6) six to nine months;

7) nine to 12 months;

8) 12 to 15 months;

9) 15 to 18 months;

10) 18 to 24 months;

11) two to three years;

12) three to four years;

13) four to five years;

14) five to six years;

15) six to eight years;

16) eight to ten years;

17) ten to 12 years;

18) 12 to 14 years;

19) 14 to 16 years;

20) 16 to 18 years; and

21) 18 to 21 years.

b) Vision Screening Periodicity Schedule

1) Vision screening using age appropriate methods shall be part of all periodic or interperiodic health screenings.

2) Beginning at age three through 20 years, the Department will pay for one vision screening performed by a qualified provider per year for an eligible child. However, the Department will pay for other such screenings when medically necessary, regardless of a child's age or medical history.

c) Hearing Screening Periodicity Schedule

1) Hearing screening using age appropriate methods shall be part of all periodic or interperiodic health screenings.

2) Beginning at age one year for children at high risk for hearing problems and age three years for all other children, the Department will pay for one hearing screening performed by a qualified provider per year for an eligible child. However, the Department will pay for other such screenings when medically necessary, regardless of a child's age or medical history.

d) Dental Screenings Periodicity Schedule

1) Examination of a child's oral cavity, including the status of the teeth and gums, shall be part of each periodic or interperiodic health screening.

2) Beginning at age two through 20 years, the Department will pay for one clinical oral examination per year and oral prophylaxis not more frequently than once every six months performed by an enrolled dentist. However, the Department will pay for other such services when medically necessary, regardless of a child's age or medical history.

e) Immunizations. The following immunizations are available to eligible clients:

1) Diphtheria-Tetanus-Pertussis (DPT) 1;

2) DPT 2;

3) DPT 3;

4) DPT Booster 1;

5) DPT Booster 2;

6) Oral Polio Vaccine (OPV) 1;

7) OPV 2;

8) OPV 3;

9) OPV Booster 1;

10) OPV Booster 2;

11) Diptheria-Tetanus (Td) 1

12) Td 2;

13) Td 3;

14) Td Booster 1;

15) Td Booster 2;

16) Measles;

17) Rubella;

18) Mumps;

19) Measles/Mumps/Rubella (M/M/R);

20) Measles/Rubella; and

21) Haemophilus b Conjugated.

f) Diagnostic Laboratory Procedures. The Department will pay for covered diagnostic laboratory procedures as medically necessary including but not limited to:

1) Urinalysis, routine (ph specific gravity protein tests for reducing substances such as glucose), with microscopy;

2) Urinalysis routine without microscopy;

3) Chemical, qualitative, any number of constituents;

4) Cholesterol, serum; total;

5) Cholesterol, serum; total and ester;

6) Lead Screening, Blood Lead;

7) Gonadotropin, chorionic quantitative pregnancy test;

8) Gonadotropin, chorionic qualitative pregnancy test;

9) Hematocrit;

10) Hemoglobin Colorimetric;

11) Sickle RBC, reduction slide method;

12) Hemoglobin Electrophoresis;

13) Sickle Hemoglobin;

14) Tuberculosis intradermal;

15) TB Tine Test;

16) Syphilis Test, qualitative;

17) GC Culture Test, bacterial screening only;

18) Culture presumptive, pathogenic organisms screening only;

19) Culture, multiple organisms;

20) Urine culture colony count;

21) Urine bacteria count, commercial kit;

22) Urine bacteria culture, identification, in addition to colony count and commercial kit;

23) Chlamydia Culture;

24) Pap Smear, Cytopathology;

25) Epidemiological study of a child's living environment when a child has been diagnosed as having an abnormally high blood lead level;

26) Denver Developmental Screening Test; and

27) Other developmental tests which may be approved by the Department.

(Source: Amended at 17 Ill. Reg. 6196, effective April 5, 1993)

Section 140.490 Medical Transportation

a) Payment for medical transportation shall be made to an individual, public, private or not-for-profit transportation carrier, whose operators are properly licensed, who provides the appropriate form of transportation and who bills and receives payment from the general public and other third party payors (except for private autos pursuant to subsection (a)(5) of this Section). Eligible providers to be considered for payment include:

1) Ambulance providers who hold a valid license, permit or certification from the state where the business is headquartered or from the Secretary of State (see Section 3-401 of the Illinois Vehicle Title and Registration Law [625 ILCS 5/3-401] and Section 8-101 of the Illinois Vehicle Code [625 ILCS 5/8-101]) and pass health/safety inspections annually by the Department of Public Health (see the Emergency Medical Services (EMS) Systems Act [210 ILCS 50]). Out-of-state ambulance providers who provide services within Illinois must be in compliance with the EMS Systems Act [210 ILCS 50]. Vehicles operated by municipalities must meet the certification requirements contained in 77 Ill. Adm. Code 535, Subpart C, by July 1, 1987. The Department will grant exceptions to this requirement if the municipality can demonstrate that the Illinois Department of Public Health has granted a waiver or exception to such requirement.

2) Medicar vehicles licensed by the Secretary of State (see Section 3-401 of the Illinois Vehicle Title and Registration Law and Section 8-101 of the Illinois Vehicle Code) or that hold a valid license, permit or certification from the state where the business is headquartered.

3) Taxicabs licensed by the Secretary of State and where applicable by local regulatory agencies (see Section 3-401 of the Illinois Vehicle Title and Registration Law and Section 8-101 of the Illinois Vehicle Code) or that hold a valid license, permit or certification from the state where the business is headquartered.

4) Service cars licensed as livery cars by the Secretary of State and where applicable by local regulatory agencies (see Section 3-401 of the Illinois Vehicle Title and Registration Law and Section 8-101 of the Illinois Vehicle Code) or that hold a valid license, permit or certification from the state where the business is headquartered.

5) Private automobiles licensed by the Secretary of State (see Section 3-401 of the Illinois Vehicle Title and Registration Law and Section 8-101 of the Illinois Vehicle Code) or licensed in the state of the owner's residence.

6) Helicopter providers who hold a valid license from the State of Illinois issued under the authority of the State of Illinois Department of Public Health, or are licensed in the state where services are provided.

7) Other modes of transportation such as buses, trains and commercial airplanes.

b) Except as provided in subsection (c) of this Section, payment for medical transportation shall be made when transportation is provided for an eligible recipient to or from a source of medical care. Medical care is defined as any medically necessary service covered under the Medical Assistance Program. Payment for transportation will be made even when a covered medical service is provided free of charge or is reimbursed by a third party (for example, services provided by the U.S. Department of Veterans' Affairs).

c) Payment for medical transportation shall not be made when:

1) A means of transportation to the source of medical care is available free of charge;

2) The transportation is for the purpose of filling a prescription or obtaining medical supplies, equipment or any other pharmacy related item; or

3) Proper prior or post approval authorization has not been made by the Department or its authorized agent.

d) When more than one passenger requiring medical services is transported, payment for the first passenger will be at the full rate including mileage, base rate and ancillaries, if provided; payment for the second or additional passengers requiring medical services will be at only the base rate and ancillaries, if provided.

e) Coverage for an employee attendant and a non-employee attendant.

1) For the purposes of this subsection (e):

A) "Employee attendant" means a person, other than the driver, who is an employee of a medicar, service car or taxicab.

B) "Non-employee attendant" means a family member or other individual who may accompany the patient when there is a medical need for such an attendant.

2) The Department will pay for an attendant to accompany an eligible patient to and from the source of a covered medical service, by a medicar, a service car or a taxicab, when the circumstances constitute one of the following medical necessities. A physician's statement may be required to verify the medical necessity.

A) To accompany the patient to a medical provider when needed, such as a parent going with a child to the doctor or when an attendant is needed to assist the patient;

B) To participate in the patient's treatment when medically necessary; or

C) To learn to care for the patient after discharge from the hospital.

3) The Department does not pay for transportation of family members to visit a hospitalized patient.

4) For dates of service prior to July 1, 2006, the use of an attendant is subject to prior approval in all situations except for the non-emergency trips described in Section 140.491(b)(2). In the instances that prior approval is not required for an attendant, medical necessity must be documented in the record. The Department's authorized prior approval agent may require documentation of medical necessity. A medicar company may bill for the services of an employee and a non-employee attendant. Billings for the services of an employee attendant and a non-employee attendant are allowable when such services are rendered during a single trip. Service car and taxicab providers may receive payment only for a non-employee attendant.

5) For dates of service on or after July 1, 2006, the use of an attendant is subject to prior approval in all situations except for the non-emergency trips described in Section 140.491(b)(2). In the instances in which prior approval is not required for an attendant, medical necessity must be documented in the record. The Department's authorized prior approval agent may require documentation of medical necessity. A medicar, service car or taxicab may bill for the services of an employee and a non-employee attendant.

f) Safety program certification requirement.

1) Safety training programs shall be approved by the Department and must include, at a minimum, all of the following components applicable to both drivers and employee attendants:

A) Passengers Assistance. Training must contain and/or convey information on courteous treatment of passengers; an understanding of different disabilities; instructions on safely loading and unloading passengers, including passengers with disability devices; and procedures for dropping off and picking up passengers.

B) Vehicle Operation and Passenger Safety. Training must contain information on vehicle inspection; proper seatbelt usage for adults; proper infant and child restraint usage, including proper method for securing child seats; and proper usage of security lock-down devices.

C) Emergency Procedures. Training must contain information on the usage of vehicle emergency equipment; procedures to follow in case of an accident or breakdown; and proper precautions and cleanup of blood borne pathogens.

2) For dates of service on or after July 1, 2008, all providers of non-emergency medicar and service car transportation must certify that all drivers and employee attendants have completed a safety program approved by the Department, prior to supplying medical transportation to a client. For services provided between July 1, 2008 and October 31, 2008, the Department will consider providers in compliance with the safety program certification requirement, if the employee driver and/or attendant completed an approved safety training program by November 1, 2008.

3) Drivers and employee attendants transporting participants of the Department's Medical Assistance programs must complete an approved safety program every three years. Documentation certifying completion of an approved safety program must be maintained by the transportation provider and available to the Department upon request. The safety program certification shall not be issued by an entity affiliated with the transportation provider.

4) The names of the driver and employee attendant actually transporting the participant shall be documented in the medical transportation service record as required at Section 140.494(a).

5) Failure of the transportation provider to maintain and, upon request from the Department, produce the documentation of required training shall

result in the recovery of all payments made by the Department for services rendered by a non-certified driver or employee attendant.

6) Exceptions to the safety program certification requirement will be permitted only in the following circumstances and documentation substantiating the exception must be available to the Department upon request.

A) The medicar or service car provider receives federal funding under 49 USC 5307 or 5311. The exception is applicable only during the period of federal funding.

B) The driver or attendant is licensed as an Emergency Medical Technician by the Illinois Department of Public Health, or comparable licensing entity in the state in which the transportation provider is located. This exception is applicable only for periods that the individual holds an active EMT license.

C) The driver or attendant holds a valid School Bus Driver Permit pursuant to 625 ILCS 5/6-106.1 and is providing services on behalf of a local education agency. This exception is applicable only for periods that the individual holds a current valid school bus permit.

(Source: Amended at 32 Ill. Reg. 17133, effective October 15, 2008)

Section 140.491 Limitations on Medical Transportation

a) For payment to be made, the transportation service must be to the nearest available appropriate provider, by the least expensive mode that is adequate to meet the individual's need. When public transportation is available and is a practical form of transportation, payment will not be made for a more expensive mode of transportation.

b) Approval from the Department, or its authorized agent, is required prior to providing transportation to and from the source of medical care, except:

1) For transportation provided by an ambulance in emergency situations.

2) For transportation provided by an ambulance for an individual who is transported from one hospital to a second hospital for services not available at the sending hospital.

3) For transportation provided by a helicopter when it is demonstrated to be medically necessary as indicated by the written order of the responsible physician in an emergency situation. An emergency may include, but is not limited to:

A) life threatening medical conditions;

B) severe burns requiring treatment in a burn center;

C) multiple trauma;

D) cardiogenic shock; and

E) high-risk neonates.

c) An on-going prior approval, with duration of up to six months, may be obtained when subsequent trips to the same medical source are required. When prior approval is sought for subsequent trips to the same medical service, the client's physician or other medical provider must supply the Department, or its authorized agent, with a brief written statement describing the nature of the medical need, the necessity for on-going visits, already established appointment dates and the number and expected duration of the required on-going visits.

d) The Department shall refuse to accept requests for non-emergency transportation authorizations, including prior approval and post-approval requests, and shall terminate prior approvals for future dates, for a specific non-emergency

transportation vendor, if:

1) the Department has initiated a notice of termination of the vendor from participation in the Medical Assistance Program; or

2) the Department has issued a notification of its withholding of payments due to reliable evidence of fraud or willful misrepresentation pending investigation; or

3) the Department has issued notification of its withholding of payments based upon any of the following individuals having been indicted or otherwise charged under a law of the United States or Illinois or any other state with a felony offense that is based upon alleged fraud or willful misrepresentation on the part of the individual related to:

A) the Medical Assistance Program;

B) a Medical Assistance Program provided in another state that is of the kind provided in Illinois;

C) the Medicare program under Title XVIII of the Social Security Act; or

D) the provision of health care services:

i) if the vendor is a corporation, an officer of the corporation or an individual who owns, either directly or indirectly, five percent or more of the shares of stock or other evidence of ownership of the corporation; or

ii) if the vendor is a sole proprietorship, the owner of the sole proprietorship; or

iii) if the vendor is a partnership, a partner of the partnership; or

iv) if the vendor is any other business entity authorized by law to transact business in the state, an officer of the entity or an individual who owns, either directly or indirectly, five percent or more of the evidences of ownership of the entity.

e) If it is not possible to obtain prior-approval for non-emergency transportation, post-approval must be requested from the Department or its authorized agent.

f) Post-approval may be requested for items or services provided during Department non-working hours or non-working hours of its agents, whichever is applicable, or when a life threatening condition exists and there is not time to call for approval.

g) To be eligible for post-approval consideration, the requirements for prior-approval must be met and post-approval requests must be received by the Department or its agents, whichever is applicable, no later than 20 work days after the date services are provided. A request for payment submitted to a third party payor will not affect the submission time frames for any post-approval request. Exceptions to the aforementioned post-approval request time frames will be permitted only in the following circumstances:

1) The Department or the Department of Human Services has received the patient's Medical Assistance Application, but approval of the application has not been issued as of the date of service. In such a case, the post-approval request must be received no later than 90 days after the date of the Department's Notice of Decision approving the patient's application.

2) The patient did not inform the provider of his or her eligibility for Medical Assistance. In such a case, the post-approval request must be received no later than six months after the date of service, but will be considered for payment only if there is attached to the request a copy of the provider's dated private pay bill or collection response, which was addressed and mailed to the patient each month after the date of service.

(Source: Amended at 31 Ill. Reg. 14749, effective October 22, 2007)

Section 140.492 Payment for Medical Transportation

Notwithstanding the provisions set forth in subsections (a) through (h) of this Section, beginning July 1, 2002, the reimbursement rates paid for medical transportation services shall be the lesser of the provider's usual and customary charge to the general public or 94 percent of the fiscal year 2002 rate otherwise determined by the Department under this Section. Payment for medical transportation services shall be made in accordance with the methodologies outlined in this Section. Base rate reimbursement is determined by the county in which the vehicle is, or the vehicles are, based. In no case shall rates exceed the Medicare allowable, where applicable, or the rates charged to the general public.

a) For dates of service prior to July 1, 2006, medicars shall be paid a base rate, which includes the first ten miles (20 miles round trip), a mileage rate and a fixed amount for an employee or non-employee attendant. Loaded miles, i.e., those miles for which the provider is actually transporting an individual, after ten miles (20 miles round trip) shall be reimbursed.

b) For dates of service prior to July 1, 2006, service cars shall be paid a base rate, which includes the first ten miles (20 miles round trip, a mileage rate and a fixed amount for a non-employee attendant. Loaded miles, i.e., those miles for which the provider is actually transporting an individual, after ten miles (20 miles round trip) shall be reimbursed.

c) For dates of service on or after July 1, 2006, medicars and service cars shall be paid at a base rate, a mileage rate and a fixed amount for an attendant, as allowed in Section 140.490(e)(5). Mileage reimbursement is made for loaded miles, i.e., those miles for which the provider is actually transporting an individual. Mileage for multiple passengers is reimbursed pursuant to Section 140.490(d).

d) Private autos shall be paid for loaded miles at a mileage rate.

e) Payment for transportation services provided by common carrier, such as commercial airplanes, buses and trains, shall be at the usual community rate.

f) Taxicabs in an area regulated by a municipality or township shall be reimbursed at the community rate and a fixed amount for an attendant, as allowed in Section 140.490(e).

g) Taxicabs in non-regulated areas shall be reimbursed at a rate as determined by the Department and a fixed amount for an attendant, as allowed in Section 140.490(e). The Department rate shall be reviewed on an annual basis each July.

h) The Department shall pay for medically necessary ambulance services provided in

accordance with Section 140.490 at a base, mileage rate (loaded miles) and a rate for oxygen, as appropriate. Payment shall also be made for Advanced Life Support (ALS) at an all inclusive, rate which includes the base rate, supplies, and all other services, excluding mileage. However, for ALS services provided on or after July 1, 1993, separate reimbursement shall be made for oxygen when used and appropriately billed. Loaded miles for ALS trips shall be reimbursed at the per mile rate. Rates shall be reviewed beginning November 1, 1986, and each November thereafter, according to the methodology set forth in subsections (g)(1) through (4) of this Section. Revised rates pursuant to this methodology shall be effective with services provided on or after July 1 of the succeeding year.

1) Payment shall be made at a basic rate that is provider specific. The basic rate shall be the lesser of the provider's usual and customary charge to the general public, as reflected on the provider's claim form, or 80 percent of the 50th percentile of the Medicare prevailing charge for Basic Life Support for the designated Medicare Locality, except that any basic rate previously approved by the Department that exceeds these parameters shall remain in force. The rate of annual increase shall not exceed five percent.

2) Payment for loaded miles shall be at a rate per mile. If a natural disaster, weather or other conditions necessitate the use of a route other than the most direct route, reimbursement will be based on the actual distance traveled. The rate per mile shall be 50 percent of the 50th percentile of the Medicare prevailing mileage charge for Medicare Locality 16. The annual rate of increase shall not exceed five percent.

3) Payment for oxygen shall be made at a flat rate statewide. The rate shall be 50 percent of the 50th percentile of the Medicare prevailing charge for Medicare Locality 16. The annual rate of increase shall not exceed five percent.

4) Payment for Advanced Life Support services shall be at the lesser of the provider's usual charge, or a maximum allowable rate statewide. The maximum rate shall be 80 percent of the difference between the Medicare 50th percentile prevailing charge for Basic Life Support services and Advanced Life Support services for Medicare Locality 16. The annual rate of increase shall not exceed five percent.

i) Payment for medical transportation services provided by individuals, including those currently receiving public assistance, legally responsible relatives or household members, will be made at a loaded mileage rate.

j) The Department may adjust reimbursement for medical transportation services in a county when such adjustment is necessary to ensure the availability of transportation to medical services.

(Source: Amended at 30 Ill. Reg. 18648, effective November 27, 2006)

Section 140.493 Payment for Helicopter Transportation

Notwithstanding the provisions set forth in this Section, beginning July 1, 2002, the reimbursement rates paid for helicopter transportation services shall be the lesser of the provider's usual and customary charge to the general public or 94 percent of the fiscal year 2002 rate otherwise determined by the Department under this Section. Payment for helicopter transportation services shall be made in accordance with the methodologies outlined in this Section. In no case shall rates exceed the Medicare allowable, where applicable, or the rates charged to the general public. The Department shall pay for medically necessary helicopter transportation services provided in accordance with Section 140.491(b)(4) at an all inclusive rate that includes base rate, mileage, supplies and all other services.

a) Helicopter transportation providers will be reimbursed a maximum rate per trip or the usual and customary charges, whichever is less.

b) If a hospital provides the transport team but does not own the helicopter, the Department will equally divide the established reimbursement rate or the usual and customary charges of the provider, whichever is less, between the hospital and the helicopter provider.

c) Hospitals that own their own helicopter and report its costs on their cost reports will not be paid for helicopter transportation services.

d) The Department shall not cover the services of helicopter transportation providers that have entered into payment agreements with receiving facilities.

e) Helicopter transportation claims that are denied because the patient does not meet the medically necessary criteria (see Section 140.491(b)(1)), but does meet emergency ground transportation criteria, will be reimbursed by the Department at the appropriate ground rate.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.494 Record Requirements for Medical Transportation Services

a) The record must, at a minimum, contain a dispatcher's log and individual trip tickets that document:

1) Identification of the client (name, address and client number);

2) Name and address or facility name of person or entity requesting service;

3) A copy of the Transportation Invoice;

4) Identification of the type of vehicle used (for example, ambulance, medicar, service car) and the vehicle's license plate number; and

5) The name of the driver and attendant, if applicable.

b) The trip ticket must document medical necessity for the following:

1) Non-emergency transportation that does not require prior approval;

2) Use of an ambulance;

3) Administration of oxygen;

4) Use of an attendant by a medicar, service car or a taxicab company; and

5) Use of a stretcher by a medicar.

c) Advanced Life Support transportation services must also maintain a copy of the Emergency Medical Services Run Sheets or other forms as required by the Illinois Department of Public Health.

d) In absence of proper and complete records, including, but not limited to, failure to provide documentation of safety training certification as required in Section 140.490(f), payments previously made shall be recouped.

(Source: Amended at 32 Ill. Reg. 17133, effective October 15, 2008)

Section 140.495 Psychological Services

a) Payment for the provision of psychological services shall be made to:

1) A psychologist in private practice.

2) State-aided Community Mental Health Clinics.

b) Payment shall be made for the provision of diagnostic psychological examinations and tests only when the services are requested by the Department for one of the following reasons:

1) to determine permanent and total disability or incapacity (see 89 Ill. Adm. Code 112.62 and 89 Ill. Adm. Code 120.314);

2) to determine the suitability of a home for a child; or

3) for planning or arranging for foster care for a child.

Section 140.496 Payment for Psychological Services

a) Payment is made to a psychologist in private practice in an amount which is the lesser of:

1) The psychologist's usual and customary charges, or

2) The prevailing rate determined by the Department based on the time involved and the tests administered.

b) Payment is made to State-aided Community Mental Health Clinics in an amount which is the lesser of:

1) The clinic's usual and customary charges, or

2) The Department approved per visit rate for the clinic.

Section 140.497 Hearing Aids

a) Hearing aids are reimbursed in accordance with Section 140.481(d).

b) In order to be eligible for reimbursement from the Department for monaural hearing aids, the following criteria must be met:

1) When testing is performed in an acoustically treated sound suite:

A) The hearing loss must be 20 decibels or greater at any two of the following frequencies: 500, 1000, 2000, 4000, 8000 Hertz; or

B) The hearing loss must be 25 decibels or greater at any one of 500, 1000, 2000 Hertz.

2) When testing is performed in other than an acoustically treated sound suite:

A) the hearing loss must be 30 decibels or greater at any two of the following frequencies: 500, 1000, 2000, 4000, 8000 Hertz; or

B) The hearing loss of 35 decibels or greater at any one of 500, 1000, 2000 Hertz.

c) The following items are to be kept in the patient's file:

1) M.D. or Otolaryngologist clearance

2) Audiogram

3) Hearing Aid Evaluation Results

4) Case history and identifying information

5) Copy of Manufacturer's invoice with patient's name and hearing aid serial number.

6) Copy of Manufacturer's invoice for ear mold, if applicable.

d) Binaural hearing aids require prior approval (see Sections 140.40 through 140.42).

e) Payment for all hearing aids is contingent upon providers fitting and dispensing

hearing aids in accordance with the requirements set forth in the Hearing Instrument Consumer Protection Act [225 ILCS 50] and implementing Public Health regulations.

(Source: Amended at 24 Ill. Reg. 661, effective January 3, 2000)

Section 140.498 Fingerprint-Based Criminal Background Checks

a) Non-Emergency Transportation

1) Non-emergency transportation vendors, as defined in Section 140.13, and applicants shall submit to a fingerprint-based criminal background check on current and future information available in the State system for criminal background checks, and current information available through the Federal Bureau of Investigation's fingerprint system, by submitting all necessary fees and information in the form and manner prescribed by the Illinois State Police. New vendor applicants must submit to fingerprint-based criminal background checks within 30 days after the submission of the application. At such times as the Department may initiate a re-enrollment of all non-emergency transportation vendors pursuant to Section 140.11(e), the Department may require such vendors to re-submit to fingerprint-based criminal background checks as provided in this Section. Fingerprint-based criminal background checks requested pursuant to Section 140.11(e) must be submitted within 60 days after the submission of such updated enrollment information. Vendors shall be responsible for the payment of the costs of fingerprint-based criminal background checks.

2) The following individuals shall be subject to the fingerprint-based background check:

A) In the case of a vendor that is a corporation, all officers and individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporate vendor.

B) In the case of a vendor that is a partnership, every partner.

C) In the case of a vendor that is a sole proprietorship, the sole proprietor.

D) Each officer and each individual with management responsibility of the vendor.

3) All individuals required to submit to a fingerprint-based criminal background check must submit their fingerprints to a fingerprint vendor approved by the Illinois State Police. The Department shall provide a list of all approved fingerprint vendors.

4) Within 30 days after any individual identified in subsection (a)(2) of this Section acquiring an ownership interest, pursuant to subsection (a)(2)(A), (B) or (C) of this Section, or assuming management responsibility, pursuant to subsection (a)(2)(D) of this Section, the vendor must notify the Department of such change and the individual must submit to a fingerprint-based criminal background check within 30 days after such notification.

5) The failure of any individual identified in subsections (a)(2)(A), (B), (C) and (D) of this Section to submit to a fingerprint-based criminal background check, as provided for in this Section, or to provide notification as required in subsection (a)(4) of this Section, will result in the denial of an application or re-application (pursuant to Section 140.11(e)) to participate in the Medical Assistance Program or may result in dis-enrollment, termination or suspension of an enrolled vendor.

6) This Section does not apply to:

A) Vendors owned or operated by government agencies; and

B) Private automobiles.

(Source: Added at 28 Ill. Reg. 4958, effective March 3, 2004)

SUBPART E: GROUP CARE

Section 140.500 Long Term Care Services

Payments to provide medical long term care services to Medicaid clients shall be made only to facilities licensed by the Illinois Department of Public Health and approved and certified for participation by that Department except such payments as are made pursuant to Section 140.504, Section 140.506 or 89 Ill. Adm. Code 104.273. These facilities include skilled nursing homes (SNF), intermediate care facilities (ICF), intermediate care facilities for the mentally retarded (ICF/MR), skilled nursing homes for pediatrics (SNF/PED), specialized living centers (SLC), and State operated facilities. Provision of and payments for long term care services are governed by Sections 140.500 through 140.907 and 89 Ill. Adm. Code 104.273.

(Source: Amended at 19 Ill. Reg. 15692, effective November 6, 1995)

Section 140.502 Cessation of Payment at Federal Direction

The Department may cease payments for the care of a resident in a long term care facility, who is eligible under the Medical Assistance Program, effective 30 days following the final disqualification of that facility by the federal government from participation in the Medicare or Medicaid programs, unless the Department shall have determined pursuant to Section 140.504 that payment should be continued for that resident.

(Source: Amended at 24 Ill. Reg. 18320, effective December 1, 2000)

Section 140.503 Cessation of Payment for Improper Level of Care

The Department may cease payments for the care of a resident in a long term care facility, who is eligible under the Medical Assistance Program, effective 30 days following the Department's decision that the facility does not provide a level of care commensurate with the level of care needed by that resident, unless the Department shall have determined that payments should be continued for that resident. The Department has sole discretion to continue payment when there are circumstances affecting the health, safety and welfare of the resident that justify continued payment. Such circumstances include, but are not limited to, alternate facility placement cannot be found or transfer of a resident, as certified by a physician, may endanger the resident's life.

(Source: Amended at 24 Ill. Reg. 18320, effective December 1, 2000)

Section 140.504 Cessation of Payment Because of Termination of Facility

a) The Department shall cease payments for the care of a Medicaid client residing in an ICF/MR facility effective 30 days following the Department's decision after hearing that the facility be terminated from participation in the Department's Medical Assistance Program, unless the Department determines, pursuant to subsection (c) below, that payments should be continued.

b) The Department shall cease payments for care of a Medicaid client residing in a nursing home (not an ICF/MR facility) effective with the termination date established by the Department, unless the Department determines, pursuant to subsection (c) below, that payments should be continued. Pursuant to 89 Ill. Adm. Code 104.208(c), the termination will be effective on such date regardless of whether any hearing requested has been completed.

c) The Department has sole discretion to continue payment after the termination date when there are circumstances affecting the health, safety, and welfare of the long term care facility's residents which justify continued payment. Such circumstances include, but are not limited to, alternate facility placement cannot be found or transfer of a resident, as certified by a physician, may endanger the resident's life.

(Source: Amended at 19 Ill. Reg. 15692, effective November 6, 1995)

Section 140.505 Informal Hearing Process for Denial of Payment for New ICF/MR Admissions

a) The Department may deny payment for new admissions to an Intermediate Care Facility for the Mentally Retarded (ICF/MR) that is found to be out of compliance with the applicable conditions of participation (42 CFR 483, Subpart I) as the result of a survey and follow-up survey conducted by the Department of Public Health (DPH). The sanction of denial of payment for new admissions shall be imposed if the facility has failed to correct cited deficiencies and comply with conditions of participation for ICFs/MR within 60 days after the exit date of the DPH initial survey. The Department shall only impose the sanction of denial of payment for new admissions if the facility has been issued a notice of termination/decertification pursuant to 89 Ill. Adm. Code 104.208(d).

b) If, at the end of the 60 days referenced in subsection (a) of this Section, the facility has not achieved compliance, the Department shall issue a written notice to the facility setting forth:

1) A statement that the Department intends to impose the sanction of denial of payment for new admissions; and

2) A statement that the facility is entitled to an informal hearing prior to imposition of the sanction.

c) Informal hearing

1) The sole issue of an informal hearing under this Section is whether the facility is out of compliance with the conditions of participation for an ICF/MR.

2) The informal hearing shall consist of the facility presenting written evidence to the Department for its review, refuting the determination that the facility is out of compliance with the conditions of participation for an ICF/MR. Such written evidence must be received by the Department within 30 days after the date of the Department's notice to the facility under subsection (b) of this Section. The Department shall review the written evidence and provide the facility with a written decision of its determination, setting forth the reasons for its determination.

3) If a facility fails to timely submit the written evidence specified above, the Department shall make a determination that payments for new admissions

be denied.

d) If the Department determines, as a result of the informal hearing, that payments for new admissions will be denied, the Department shall issue a written notice to the facility informing it that the denial of payment for new admissions will be imposed on a specified date that shall not be fewer than 15 days after the date of the notice.

e) The denial of payments for new admissions shall remain in effect until the Department is notified by DPH that the facility has come into compliance with the conditions of participation.

(Source: Old Section repealed at 19 Ill. Reg. 15692, effective November 6, 1995; New Section added at 24 Ill. Reg. 18320, effective December 1, 2000)

Section 140.506 Provider Voluntary Withdrawal

a) A long term care facility may voluntarily withdraw from participation in the Medical Assistance Program by notifying the Department in writing at least 60 days prior to the effective date of the withdrawal.

b) If a long term care facility informs the Department that it intends to withdraw from the Medical Assistance Program, the Department shall not pay for the care of new admissions to the facility on or after the effective date of voluntary withdrawal.

c) The Department shall continue to pay for the care of individuals who are residing in a facility which voluntarily withdraws from participation in the Medical Assistance Program provided that

1) Payment is not terminated by operation of Sections 140.502, 140.503 or 140.504.

2) The facility continues to receive certification surveys and enters into provider agreements.

3) The individual has continuously resided in the facility since the day before the effective date of the facility's voluntary withdrawal with the Department.

(Source: Amended at 24 Ill. Reg. 18320, effective December 1, 2000)

Section 140.507 Continuation of Provider Agreement

If the Department continues to pay for a recipient in a group care facility with which the Department no longer has a currently effective provider agreement, the terms of the provider agreement previously in force shall be deemed to continue in force for the purposes of governing the relationship between the provider and the Department in respect to the recipient or recipients remaining in the facility for as long as the recipient remains in that facility as a recipient.

Section 140.510 Determination of Need for Group Care

The Department, or its designee, shall verify the initial need for group care in accordance with Section 140.642. The Department shall verify the continued need for group care in accordance with Sections 140.512 (b)(3) and (4), 140.850 through 140.880, and 140.900 through 140.902. The prior approval of the Department or its designee is required before payments will be authorized for a recipient admitted to a group care facility. Approval shall be based on a determination that a need for group care exists and that the provider meets the participation requirements of Sections 140.11 and 140.12.

(Source: Amended at 11 Ill. Reg. 2323, effective January 16, 1987)

Section 140.511 Long Term Care Services Covered By Department Payment

Skilled nursing facilities and intermediate care facilities (SNF and ICF) and intermediate care facilities for the mentally retarded (ICF/MR) providing long term care to Medicaid eligible residents shall provide the following services at no additional charge:

a) All staff, routine equipment and supplies including oxygen (if less than one tank has been furnished to the resident for the month in question);

b) Room and board, supervision and oversight, and all laundry services;

c) Food substitutes and nutritional supplements;

d) Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under Department of Public Health regulations;

e) Over-the-counter drugs or items ordered by a physician (including but not limited to, drugs and items listed in the Department's Long Term Care Provider Handbook, Appendix C-26, and excluding drugs and items reimbursed under the Department's Drug Program); and

f) All other services necessary for compliance with the requirements of the Department of Public Health as set forth in the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300) and the Intermediate Care for the Developmentally Disabled Facilities Code (77 Ill. Adm. Code 350).

(Source: Amended at 17 Ill. Reg. 6839, effective April 21, 1993)

Section 140.512 Utilization Control

Each intermediate care facility for the mentally retarded (ICF/MR) shall have a written Utilization Review (UR) Plan on file that provides necessary information about each client that is necessary for the Department or its designee to perform UR; see 42 CFR 456.401 – 456.438 (1989). The Individual Program Plans which are written for each client residing in the facility can satisfy this requirement.

a) The Department or its designee shall conduct medical and utilization reviews (UR) in conjunction with the Inspection of Care (IOC) Program, to insure the quality of care provided to residents of ICF/MR facilities.

b) Inspections of Care of ICFs/MR shall be conducted in accordance with the provisions of 42 CFR 456, Subparts F and I (1989) to evaluate:

1) The care being provided to clients;

2) The adequacy of services available in a particular facility;

3) The necessity and desirability of continued placement in a particular facility;

4) The feasibility of alternative solutions to continued placement in a particular facility;

5) The facility's Utilization Review Plan; and

6) The written plan of care for each client.

c) Inspections of Care of nursing facilities (skilled care and intermediate care facilities) shall be conducted to evaluate all items indicated above with the exception of subsection (b)(5) above.

(Source: Amended at 16 Ill. Reg. 6849, effective April 7, 1992)

Section 140.513 Notification of Admissions and Changes in Resident Status

a) All long term care providers shall report admissions and all changes in resident status, including, but not limited to, death, discharge, bed reserve/temporary absence, changes in patient credit, third party liability (TPL) and Medicare coverage, to the Department through the Medical Electronic Data Interchange (MEDI) system or through the Recipient Eligibility Verification (REV) System (see Section 140.55).

b) All admissions and changes in resident status shall be reported through MEDI or REV within five working days after the change occurs.

c) Reported admissions and changes in resident status shall be used for the purposes of determining Medicaid reimbursement. Income verification for any patient credit change and forms required for admission shall continue to be submitted to the Department of Human Services local office caseworker. All admissions and changes in resident status are subject to Department review.

d) Failure to comply with the requirements outlined in this Section may result in denial or delay of payment or termination or suspension of the facility's participation in the Medical Assistance Program.

(Source: Amended at 34 Ill. Reg. 19517, effective December 6, 2010)

Section 140.514 Certifications and Recertifications of Care (Repealed)

(Source: Repealed at 27 Ill. Reg. 14799, effective September 5, 2003)

Section 140.515 Management of Recipient Funds – Personal Allowance Funds

a) The recipient, the correspondent or the facility may manage the recipient's personal allowance funds.

b) The monthly personal allowance of each recipient is that individual's personal property. The personal allowance may be used or accumulate as the recipient or correspondent wishes.

c) Personal allowance funds may be accumulated by the recipient as part of allowable assets up to the asset disregard. All monies accumulated in excess of the allowable asset limit shall be applied toward the cost of care.

Section 140.516 Recipient Management of Funds

If the recipient manages the funds, that individual shall promptly report changes in circumstances to the local office and notify the local office of any lump sum payment received.

Section 140.517 Correspondent Management of Funds

If the correspondent manages the funds, that individual shall:

a) Report changes in the recipient's circumstances to the local office;

b) Expend the funds for the recipient's benefit;

c) Keep an accurate record of all expenditures;

d) Safeguard the confidentiality of the recipient's funds; and

e) Notify the local office of any lump sum payment received.

Section 140.518 Facility Management of Funds

A facility shall manage a resident's personal funds only upon the written authorization from, in order of priority, the resident, the resident's guardian, the resident's representative, or the resident's immediate family member. Such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations and who is not connected in any way to facility personnel or the administrator in any manner. If the facility manages such personal funds, it shall:

a) Establish a separate, written record of each resident's account;

b) Provide a written record of the account at least quarterly to each resident or authorized representative included in the account;

c) Retain all records of personal allowance funds for three (3) years for residents currently residing in the facility and for residents who have died or been discharged from the facility;

d) Report changes in circumstances to the local office;

e) Notify local office of any lump sum payment received;

f) Keep resident funds in an account or accounts which are separate from any facility operating funds or the funds of any person other than another resident. The facility shall establish and maintain a system that assures a full and complete and separate accounting of each resident's account balance. For resident funds that are commingled with the funds of other residents, all interest earned on the resident's funds shall be pro-rated and properly credited to each resident's account balance. The system shall contain documents identifying all transactions made by the facility on behalf of the resident. All deposits and withdrawals are to be shown by date and amount and identifiable receipts for all purchases must be retained; and

g) Notify each resident who receives Medicaid benefits when the amount in the resident's account reaches $200.00 less than the SSI resource limit for one person. The facility must notify the resident that the amount in the account, in addition to the value of the resident's other nonexempt resources, exceeds the one person SSI resource limit of $2,000.00.

(Source: Amended at 15 Ill. Reg. 17733, effective November 22, 1991)

Section 140.519 Use or Accumulation of Funds

The facility or correspondent shall not expend or allow use of recipient funds for any person other than the recipient. The facility and Department shall explain to the recipient or correspondent that funds are not to be spent for the purchase of or as a contribution toward the purchase of items/equipment that the facility is required to provide for the recipient.

Section 140.520 Management of Recipient Funds – Local Office Responsibility

The local office shall:

a) Review each recipient's personal allowance account during the determination/redetermination process;

b) Provide advice and consultation to the recipient regarding handling of personal allowance funds; and

c) Provide counseling to the recipient regarding requests to purchase certain items/equipment normally provided by the facility.

Section 140.521 Room and Board Accounts

a) A room and board account is a record of transactions about the patient's cost of care, all monies received which may be applied to the cost of care and the current balance of the account.

b) If a facility has a room and board account for the recipient it shall:

1) Maintain a ledger of all information pertaining to the recipient's expenditures and receipts of all monies of the account.

2) Maintain a written record of each recipient's account in which all transactions are identifiable.

3) Notify the local office of the receipt of any lump sum payment.

c) If funds accumulated at the end of the eligibility period exceed the allowable asset disregard, the excess shall be applied to the recipient's cost of care.

d) Local office staff review the room and board account at the time of the redetermination of eligibility.

Section 140.522 Reconciliation of Recipient Funds

a) Upon death or discharge of the recipient, the facility shall:

1) File a report of the amount of monies held in the recipient's account with the local office.

2) Promptly refund any money belonging to the recipient or the recipient's authorized representative.

b) The local office shall file a claim, if appropriate, against the deceased recipient's estate.

Section 140.523 Bed Reserves

a) Nursing Facilities

1) All payable bed reserves must:

A) be authorized by a physician;

B) have post payment approval from Bureau of Long Term Care staff based on satisfying the requirements of this Section;

C) be limited to residents who desire to return to the same facility; and

D) be limited to facilities having a 93 percent or higher occupancy level and, of that occupancy level, 90 percent or higher shall be Medicaid eligible. The occupancy level shall be calculated including both payable and non-payable (non-payable defined as those residents that have transitioned from the maximum days allowed for payable bed reserve to non-payable bed reserve status) bed reserve days as occupied beds.

2) The Department shall make payment for resident absences due to hospitalization. In such instances, bed reserve is limited to ten days per hospital stay. In accordance with the Nursing Home Care Act [210 ILCS 45/3-401.1], a recipient or applicant shall be considered a resident in the nursing facility during any hospital stay totaling ten days or less following a hospital admission. The day the resident is transferred to the hospital is the first day of the reserve bed period.

3) Payment may be approved for home visits which have been indicated by a physician as therapeutically beneficial. In such instances, bed reserve is limited to seven consecutive days in a billing month or ten non-consecutive days in a billing month. The day after the resident leaves the facility for a therapeutic home visit is the first day of the payable or non-payable reserve bed period. Home visits may be extended with the approval of the Department.

4) Bureau of Long Term Care staff will approve ongoing therapeutic home visits based on the physician's standing orders for the individual. Standing orders for therapeutic home visits limited to ten days per month are valid for a period not exceeding six months.

5) Payment for approved bed reserves is a daily rate at 75 percent of an individual's current Medicaid per diem.

6) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.

b) ICF/MR Facilities (including ICF/DD and SNF/Ped licenses)

1) All bed reserves must:

A) be authorized by the interdisciplinary team (IDT); and

B) be limited to residents who desire to return to the same facility.

2) There is no minimum occupancy level ICF/MR facilities must meet for receiving bed reserve payments.

3) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.

4) Payment may be approved for hospitalization for a period not to exceed 45 consecutive days. The day the resident is transferred to the hospital is the first day of the reserve bed period. Payment for approved bed reserves for hospitalization is a daily rate at:

A) 100 percent of a facility's current Medicaid per diem for the first ten days of an admission to a hospital;

B) 75 percent of a facility's current Medicaid per diem for days 11 through 30 of the admission;

C) 50 percent of a facility's current Medicaid per diem for days 31 to 45 of the admission.

5) Payment may be approved for therapeutic visits which have been indicated by the IDT as therapeutically beneficial. There is no limitation on the bed reserve days for such approved therapeutic visits. The day after the resident leaves the facility is the first day of the bed reserve period.

Payment for approved bed reserves for therapeutic visits is a daily rate at:

A) 100 percent of a facility's current Medicaid per diem for a period not to exceed ten days per State fiscal year;

B) 75 percent of a facility's current Medicaid per diem for a period which exceeds ten days per State fiscal year.

(Source: Amended at 29 Ill. Reg. 831, effective January 1, 2005)

Section 140.524 Cessation of Payment Due to Loss of License

Payment to a long term care facility for services to Public Aid recipients will cease effective 30 days following notice from the Illinois Department of Public Health that the facility is no longer licensed.

(Source: Added at 10 Ill. Reg. 11440, effective June 20, 1986)

Section 140.525 Quality Incentive Program (QUIP) Payment Levels

a) For the period beginning July 1, 1991, and ending January 31, 1992, Quality Incentive Program (QUIP) payments are:

1) For nursing facilities, the amount they were eligible for under QUIP as of July 1, 1991. Additionally, all nursing facilities, regardless of QUIP status, receive $.96 per resident, per day for this period.

2) For ICF/MR facilities, $2.57 per resident, per day.

3) For developmental training (DT) agencies, $9.33 per month for each DT client.

b) For the period beginning February l, l992, and ending June 30, l992, QUIP payments are reduced to 5l.7% of the amount the facility or DT agency was receiving as of January 31, l992.

c) Effective July l, l992, no QUIP related payments will be made.

(Source: Amended at 17 Ill. Reg. 837, effective January 11, 1993)

Section 140.526 County Contribution to Medicaid Reimbursement (Repealed)

(Source: Repealed at 34 Ill. Reg. 3761, effective March 14, 2010)

Section 140.527 Quality Incentive Survey (Repealed)

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.528 Payment of Quality Incentive (Repealed)

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.529 Reviews (Repealed)

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.530 Basis of Payment for Long Term-Care Services

a) The amount approved for payment for long term care services is based on the type and amount of services required by and actually being furnished to a resident and is determined in accordance with the Department's rate schedule.

b) Costs not related to patient care, as well as costs in excess of those required for the efficient and economical delivery of care, will not be reimbursed.

c) Rates and payments

1) Rates for long term care services shall be the sum of the reimbursable costs of capital, support, and nursing, as defined in this Part and 89 Ill. Adm. Code 147.

2) Additionally, for county-owned or operated nursing facilities, rates shall include allowable costs incurred in excess of the reimbursable costs defined in this Part and 89 Ill. Adm. Code 147. Costs in excess of reimbursable costs shall be certified from the signed annual cost report submitted by the county to the Department.

3) 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.

4) Payments by the Department for long term care services shall not exceed reimbursable costs as defined in this Part and 89 Ill. Adm. Code 147 less what is contributed by third party liability.

d) Definitions

1) "Allowable costs" are those which are appropriate patient care expenditures as defined in this Part and 89 Ill. Adm. Code 147.

2) "Reimbursable costs" are determined by the application of statistical standardizations of allowable costs for all providers within various defined groups to the costs of individual providers within such groups.

3) "County-owned nursing facility" is a nursing facility owned and operated by an Illinois county.

(Source: Amended at 34 Ill. Reg. 3761, effective March 14, 2010)

Section 140.531 General Service Costs

General service costs are allowable as follows:

a) Dietary – Allowable dietary costs include salaries and wages earned by those preparing food, serving food, and dishwashing; fees paid to dietary consultants; supplies used in preparing and serving food; and other items such as soaps and detergents, menus, aprons and uniforms for dietary personnel.

b) Donated Goods – The fair market value of nondepreciable, care related, donated goods is an allowable cost.

c) Food – The cost of food and food supplement items are allowable. If meals are sold to employees or visitors, the cost of these meals is not allowable. The cost of employee meals is allowable only if they are provided at no cost to the employee and if their provision is required by contract or is explicitly stated in the facility's written wage Personnel policies. If employee meals are provided at no cost, they must be reported on the cost report as employee benefits.

d) Heat and Other Utilities – Cost of fuel or electricity to heat and cool the facility is allowable.

e) Housekeeping – Allowable costs include salaries and wages of housekeepers, maids, porters, janitors, etc., and supplies such as brooms, brushes, cleaning compounds, disinfectants, germicides, insecticides, mops, polish, soap, paper towels, and drinking cups.

f) Laundry – Allowable costs include salaries and wages of laundry personnel, and supplies such as linens and soaps, detergents and bleaches to operate laundry service. If laundry services are purchased, the expense is allowable. If laundry services are sold, the cost of such services is not allowable.

g) Maintenance – Allowable costs include salaries and wages of maintenance personnel; supplies, parts, and materials required to maintain building and equipment; inspection fees for elevators and builders; expense of outside contractors to repair or maintain building or equipment.

Section 140.532 Health Care Costs

Health care costs are allowable as follows:

a) Activities – Allowable costs are salaries and wages paid to employees working in the activity program, supplies used in the program, and expenses incurred for religious services.

b) Daycare and Outpatient Services – The cost of daycare and outpatient services is not allowable.

c) Medical Director – The salary or fee paid to a physician serving as medical director is allowable. If the medical director provides routine care to patients, that portion of his salary due to providing direct care is not an allowable cost and must be allocated to ancillary services based on number of hours spent in each function.

d) Non-Paid Workers – Allowable costs are salaries at the value that would be paid if employees were hired, only if volunteers are used to meet minimum standards and cost is determinable.

e) Nursing and Medical Records – Allowable costs are salaries and wages paid to nurses, aides, orderlies, and medical records personnel; consultant fees; and nursing supplies such as adhesive tape, dressings, gauze, rubber goods, thermometers, oxygen, diapers, and group care restricted drugs (non-prescription medicines). Facilities shall not reclassify cost of nurses reported for staff requirements to other sections of cost report forms. Revenue derived from providing medical records information to interested parties must be used to offset cost.

f) Social Services – Allowable costs are salaries and wages paid to employees working in the social service program, as well as supplies incidental to the program.

Section 140.533 General Administration Costs

General administration costs are allowable as follows:

a) Administrative – Allowable costs are reasonable costs of salaries paid to the administrator and assistant administrator (reasonableness to be determined by hours worked, need for position, and prevailing salaries in the industry); central office expenses in accordance with Medicare guidelines; and miscellaneous administrative expenses not otherwise classified. Compensation paid to a nonworking officer or owner is not allowable.

b) Bad Debts – Costs attributed to uncollectable accounts are not allowable. This includes professional fees incurred for the collection of such accounts.

c) Clerical – Allowable costs are salaries and wages of clerical staff, office supplies, printing, postage, copier expenses, telephone and telephone leasing expense, and other miscellaneous expenses. Clerical costs relating to fund raising or other non-care activities are not allowable.

d) Contributions – Contributions made to charitable or political organizations are not allowable.

e) Directors' Fees – Reasonable fees paid to directors are allowable. Reasonableness will be determined by the duration of the meeting and the customary directors' fees paid by similar institutions. The director must attend the meeting in order for a director's fee to be allowable. Auditable records indicating attendance and duration of meetings must be kept.

f) Dues, Fees, Subscriptions, Promotions – Reasonable cost of membership in organizations reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care is allowable. The cost of membership in civic, social, or fraternal organizations is not allowable. The cost of subscriptions to professional, technical, or business related periodicals is allowable. Allowable advertising costs include: those in connection with recruiting personnel, or for procurement of scarce items or services related to patient care. Advertising costs are not allowable in connection with public relations, fund raising, or to encourage patient utilization. Trust fees are also a non-allowable expense.

g) Employee Benefits and Payroll Taxes – Allowable costs include retirement plans, life insurance, health insurance, malpractice insurance for the medical director, payroll taxes, uniform allowance, unemployment insurance, workmen's compensation and employee meals. Benefits claimed as costs must be required by law, a written contract, or written policies of the facility. Premiums on

key-man life insurance where the corporation or facility is the beneficiary, or where similar insurance is not available to all employees are not allowable except as required by lending institutions.

h) Good Will and Covenant not to Compete – Costs are not allowable.

i) Inservice Training and Education – Allowable costs are travel, food, lodging, attendance fees, and cost of bringing training personnel to the facility. The cost of training employees or volunteers who will work in the facility is allowable. The cost of training non-employees is not allowable.

j) License or Application Fees – Fee for licensure of the facility as well as the license application fee are allowable costs.

k) Malpractice Insurance – Cost of malpractice insurance for the facility is allowable.

l) Professional Services – Reasonable legal and accounting fees incurred incident to the operation of the facility are allowable. Legal and accounting costs incident to corporate matters not related to patient care are not allowable. Retainer fees are also not allowable. Legal fees for law suits against the State or Federal governments are not allowable. Management fees are allowable to the extent they are reasonable in relation to services performed.

m) Property and Liability Insurance – The cost of property and liability insurance premiums paid on care related assets is an allowable cost.

n) Travel and Seminar – The reasonable and necessary cost of attending meetings and seminars (related to patient care) is an allowable cost. Travel, lodging, food and registration expenses related to attending conferences and conventions beyond 50 miles of Illinois are not allowable. Conferences held in-state, or within 50 miles of Illinois are allowable under the following conditions:

1) The conference is specifically of an educational nature (i.e., improvements of skill levels). Meetings directed towards lobby activities are not considered educational.

2) Staff in attendance are those involved in supervising and providing direct care to clients.

3) Costs associated with other than direct care staff (e.g., accountant, bookkeeper, dietary, housekeeping) are allowable when attendance at a

conference was at the request of, or sponsored by, the state, or if the seminar is directly related to government cost reporting and reimbursement.

o) Utilization Review – Reasonable expenses incurred in utilization review in skilled cases are allowable.

(Source: Amended at 12 Ill. Reg. 19396, effective November 6, 1988)

Section 140.534 Ownership Costs

Ownership costs are allowable as follows:

a) Depreciation
Depreciation on care related assets is an allowable cost subject to the following conditions:

1) Depreciation must be computed on a straight-line basis, starting from the date of completion or installation.

2) Depreciation must be based on historical cost of the asset (purchased assets) or fair market value at the time of donation or inheritance of the asset (donated or inherited assets).

3) Depreciation must be spread over the useful life of the asset using the American Hospital Association guidelines followed by Medicare at a minimum.

b) Acquisitions of Fixed Equipment
If an item has at the time of its acquisition an estimated useful life of at least two years and a historical cost of at least $2,500, its cost must be capitalized and depreciated over the estimated useful life of the asset using the straight-line method of depreciation. If an item has an historical cost of less than $2,500, or if the item has a useful life of less than two years, its cost must be expensed in the cost report year it was incurred.

c) Betterments and Improvements
Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (for example, asbestos removal) of an asset as opposed to repairs and maintenance that either restore the asset to, or maintain it at, its normal or expected service life. To be capitalized, the betterment or improvement must be $2,500 or more. Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset valuation. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not a betterment or improvement but an expense of that period.

d) Repair Costs
Repair costs restore the asset to normal working condition and expected service life. Single items of repair that cost $2,500 or more and have a life of two years or more are to be considered as capital improvements and depreciated over the

useful life of the item. All other repairs must be expensed in the cost report year the cost was incurred. Maintenance costs are always expensed in the cost report year in which they are incurred.

e) Movable Equipment Costs
Single items of movable equipment at a cost of $2,500 or more having an estimated useful life of two years or longer must be capitalized. For cost reporting purposes, the term movable equipment will include all equipment items referred to in the most current edition of the American Hospital Association guidelines followed by Medicare. Items purchased in quantity must also be compared to the $2,500 threshold.

f) Painting and Wallpaper
Painting and wallpapering costs of $2,500 or more in total for the year will be allowed to be capitalized and depreciated over five years. When the cost is fully depreciated, it must be removed from the cost report in the year it becomes fully depreciated. The choice of whether to capitalize these costs must be made at the time the cost report is filed. . If total costs are under $2,500 or an election to capitalize and depreciate over five years is not made, the painting and wallpapering costs must be expensed in the year incurred. Once the cost report is properly filed, no changes to the classification of the painting and wallpapering costs will be allowed

g) Disposal of Assets
For building costs, only capital assets that are specifically identified on the cost report are capable of being removed from the cost report as a retired or disposed of asset. Movable equipment items should be removed from the cost report when they are retired. Depreciable assets may be disposed of through sale, scrapping, trade-in, donation, exchange, demolition, abandonment or involuntary conversions such as condemnation, fire, theft or other casualty. When an asset has been retired from active service but is being held for standby or emergency services, the asset must be reported in the non-care section of the cost report.

h) Central Office Assets
For building costs allocated from a central office, the total cost allocation to an individual facility is limited to five percent of the total building cost for the current owner of the nursing home building. If the current operator leases the building from an unrelated party, the five percent is limited to the "Original Building Base Cost" as defined in Section 140.570. The central office allocation is not included in the total building cost for the current owner or the "Original Building Base Cost" that will be used in the five percent calculation. Allocated central office buildings are subject to the standards of Section 140.563.

i) Partnership Assets
The basis of assets of a partnership are not allowed to be increased due to a partner buyout.

j) Change of Ownership
For any change of ownership after July 18, 1984, the cost basis of any asset for determination of allowable depreciation expense shall be the lesser of the allowable acquisition cost of the asset of the first owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner.

(Source: Expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006)

Section 140.535 Costs for Interest, Taxes and Rent

a) Allowable costs for interest expenses

1) Interest – Reasonable and necessary interest on both current and capital indebtedness is an allowable cost provided that the indebtedness is related to patient care. No interest cost shall be recognized to the extent it exceeds payment used on 125 percent of the prevailing mortgage rate at the time of the loan. Interest paid on loans from the providers' donor-restricted funds or qualified pension fund is allowable. Interest income from unrestricted funds must be used to offset allowable interest expense. Interest incurred during construction must be capitalized and amortized over the life of the asset. Interest penalties are not allowable costs. Interest on loans to purchase capital stock are not allowable costs.

2) Effective for the rate year beginning July 1, 1984, for sales occuring January 1, 1978, and after, where the increased capital cost is deemed unreasonable, and adjustment to interest expense is made, the principal on which interest is computed must be reduced by the excess of the purchase price over the calculated reasonable capital expense.

b) Rent – Reasonable amounts expended for the rental of care related assets are allowable insofar as they represent arms length transactions between the owners of the property and the party claiming the expense. Subleases are not an allowable expense. Rents paid to related organizations are not an allowable expense. (Capital costs of related organizations must be itemized.) Real estate and personal property taxes included in rental amounts should be claimed as a tax expense.

c) Taxes – Real estate and personal property taxes on care related assets are allowable capital costs. Special assessments on land which represent capital improvements such as sewers, water, and pavements must be capitalized and depreciated over their estimated useful lives. Fines and penalties associated with property taxes are not an allowable cost. The personal property replacement tax is not allowable.

1) A facility that is organized as a not-for-profit entity must attach a copy of a denial of an application for exemption from real estate taxes, to the cost report filed with the Department. This exemption denial should be no more than four years old at the time the cost report is filed. A not-for-profit entity that leases the building from a for-profit entity does not have to attach a denial report.

2) Starting with cost reporting periods ending in 1994, if the long term care facility chooses to appeal an increase in real estate tax, the direct cost of that appeal may be reported as a real estate tax cost instead of a professional fee cost. An example of this cost would be a fee paid to a lawyer to prepare the appeal. Indirect costs such as overhead costs cannot be reported as a real estate tax appeal cost. Only fees paid to lawyers or organizations which specialize in real estate tax appeals may be considered to be a direct appeal cost. Services provided by related entities as defined in Section 140.537 may not be classified as a real estate tax cost. Professional fees may not be reported as a real estate tax cost if no appeal is filed. A copy of the invoice which provides details of services provided must be submitted with the cost report. A copy of the decision from the real estate tax appeal board must also be submitted with the cost report for the year in which the decision was received.

(Source: Amended at 19 Ill. Reg. 15692, effective November 6, 1995)

Section 140.536 Organization and Pre-Operating Costs

a) Material pre-operating and organization costs must be capitalized and amortized ratably over a 60 month period starting with the month the first patient is admitted. Allowable organization costs include legal fees incurred in establishing the corporation or other organization, necessary accounting fees, expenses of temporary directors, and organizational meetings of directors and stockholders. Fees paid to States for incorporation costs relating to the issuance and sale of shares of capital stock or other securities are not allowable.

b) Pre-operating costs are incurred from the time preparation begins on a building, wing, or floor to the time the first patient is admitted. If material, these costs must be amortized to cover a 60 month period. Pre-operating costs include administrative and nursing salaries, heat, gas, and electricity, taxes, insurance, mortgage and other interest from the completion of construction until the first patient is admitted, employee training costs, housekeeping, and any other allowable costs incident to the standard period.

c) Expenditures attributable to the negotiation or settlement of the sale or purchase of any capital asset (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) shall not be considered to be allowable costs for cost reporting and reimbursement purposes.

(Source: Amended at 9 Ill. Reg. 19138, effective December 2, 1985)

Section 140.537 Payments to Related Organizations

a) Related organizations include those with overlapping ownership and organizations with any ownership interest held by relatives of the owners of the reporting facility. Relatives include spouses, children, parents, brothers, sisters, grandparents, grandchildren, parents-in-law, sister or brother-in-law, son or daughter-in-law, aunt, uncle, and cousins. Where the overlapping ownership or interest held by relatives is 5 percent or more, a related organization exists for cost reporting purposes. An organization which has any control over operating policy of the reporting facility shall also be considered a related organization.

b) The following criteria govern costs regarding payments to related organizations:

1) Where facility makes rental payments to a related organization the rental payments are not allowable. The capital costs of the related organization must be used.

2) Interest paid by a facility to a related organization is allowable to the extent it does not exceed the prime rate of interest. The funds borrowed must be directly related to patient care. Interest is not allowed on loans from related parties in order to compensate or pay dividends to related parties, or to replace working capital used to pay for non-allowable expenses. Funds provided by owners to replace operating losses are contributions to capital and not allowable.

3) The cost of supplies or services purchased from a related organization are allowable if the following conditions are met:

A) Supplying organization is a bona fide separate organization;

B) At least 95 percent of the business activity of the type carried on with the facility is conducted with unrelated organizations;

C) The charge to the facility is in line with charges to unrelated customers; and

D) The charge to the facility does not exceed fair market value.

c) If all the above criteria are not met, the cost of the related organization must be used.

Section 140.538 Special Costs

a) Transportation – The costs of transportation that is medically necessary and is of the type reimbursed by Public Aid in addition to the routine rate is not allowable. Other types of patient related transportation costs should be classified as either administrative costs or activity costs and are allowable.

b) Ancillary Services – are not an allowable expenditure. Ancillary services are those services which are not explicitly required by licensing requirements. Accordingly, the definition of ancillary service differs by licensure type, particularly between SNF and ICF, as compared to ICF/MR facilities.

c) For SNF or ICF, the following are ancillary services: occupational therapy by a licensed therapist, recreational therapy by a licensed therapist, dental care, work-related programs, rehabilitation by licensed personnel, pharmacy (other than "group care restricted"), psychological services (evaluation and diagnosis/behavior modification), and academic education by licensed personnel.

d) These services, when offered by the above practitioners are ancillary services whether they are offered in the facility or outside the facility. Note, this does not include consultants or services offered by unlicensed personnel within the facility even if they relate to the above program areas.

e) In an ICF/MR or SNF Pediatric facility the following services are ancillary: physician care, dental care – except for dental screening, work-related programs (other than Level I Developmental Training and Level II Developmental Training as defined in Section 140.647, Description of Day Programming Service Levels), pharmacy (other than "group care restricted"), academic education, and any service for which the individual practitioner bills the Department directly or any service for which the Provider directly bills another Department or another governmental unit, including local school districts.

f) It is the responsibility of the individual provider to obtain prior approval before rendering ancillary services. Ancillary providers must be enrolled with the Department.

g) Oxygen in excess of one tank per patient per month is reimbursed directly rather than as part of the per diem. In order to submit claims the facility must be enrolled as a provider of oxygen.

h) Barber and Beauty Shops – Costs associated with barber and beauty shops are not allowable.

i) Coffee and Gift Shops – Costs associated with coffee and gift shops are not allowable.

j) Assessment fees required by Public Act 87-861 or Public Act 88-88 to be paid to the Department of Public Aid are not an allowable cost for reimbursement purposes. This fee must be reported on the cost report Schedule V, Section E, Special Cost Centers, Line 42.

(Source: Amended at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.539 Reimbursement for Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide Training and Nursing Assistant Competency Evaluation

a) Training Reimbursement

1) Long term care facilities shall be reimbursed for the reasonable costs of assistant and aide training. Upon the individual's successful completion of a course which has been approved by the Department of Public Health (77 Ill. Adm. Code 395.110), the facility may claim reimbursement for the following costs, provided that they are actually incurred:

A) tuition, up to the prevailing community college rate in the health service area for a six credit hour course;

B) instructional materials, up to $25.00; and

C) salary and fringe benefits (fringe benefits are payroll taxes, unemployment insurance, worker's compensation, health insurance and meals if provided) up to the prevailing entry level for the health service area.

2) The Department will reimburse for actual approved hours up to 130 hours.

3) Facilities shall also receive an additional factor of five percent of the total claim to recognize costs for those who do not successfully complete the course.

4) The Department shall reimburse on a pro rata basis according to the percentage of Medicaid residents in the facility at the time the request for reimbursement is submitted to the Department.

5) Successful completion of a course by each individual for whom reimbursement is being requested shall be verified through the Department of Public Health Nurse Aide Registry. In the event that an individual's name does not appear on the Registry within three months after the Department's receipt of the reimbursement request, the Department reserves the right to request documentation that shows proof of:

A) submittal of the individual's name for entry on the Nurse Aide Registry (for example, a copy of the notification to the Department

of Public Health), if applicable, and

B) successful completion of the course by the individual (for example, an instructor signed attendance form or other instructor certification).

6) No individual who is employed by, or who has received an offer of employment from, a facility on the date on which the individual begins a Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide or Habilitation Aide training program may be charged for any portion of the program (including any fees for textbooks or other required course materials). This provision applies whether or not the facility requests Medicaid reimbursement for the training, the individual fails the competency exam or the individual subsequently leaves employment.

b) Basic Nursing Assistant Competency Evaluation

1) Nursing facilities shall be reimbursed for the reasonable costs for basic nursing assistant competency evaluations. Only evaluations approved by the Department of Public Health are reimbursable. The facility may claim reimbursement for the cost of each approved competency evaluation successfully completed with a passing grade.

2) Payment will not be made under this Section for costs incurred in administering tests not approved by the Department of Public Health, or for any additional tests administered by the facility during or subsequent to basic nursing assistant training.

3) Payment will be made for all competency evaluations successfully completed with a passing grade after October 1, 1989.

4) The maximum reimbursable cost per competency evaluation successfully completed with a passing grade is the current fee charged by the Department of Public Health approved evaluation service. The Department will reimburse on a pro rata basis according to the percentage of Medicaid residents in the facility at the time the request for reimbursement is submitted to the Department. The Department will not pay any other costs associated with the evaluation process.

5) No payment will be made for any competency evaluation in which a failing grade is received for any part of the evaluation. An individual must pass both the demonstration of manual skills and written components of

the evaluation before reimbursement may be claimed.

6) Passage of the competency evaluation for each individual for whom reimbursement is being requested shall be verified through the Department of Public Health Nurse Aide Registry. In the event that an individual's name does not appear on the Registry, the Department reserves the right to request documentation of such passage before authorizing payment. Competency evaluations do not apply to Basic Child Care Aides, Habilitation Aides or Developmental Disabilities Aides.

7) Facilities shall receive an additional factor of five percent of the total claim to recognize costs for those who do not successfully pass the evaluation.

8) No individual who is employed by, or who has received an offer of employment from, a facility on the date on which the individual begins a basic nursing assistant program may be charged for any costs associated with competency evaluation. This provision applies whether or not the facility requests Medicaid reimbursement for the competency evaluation, the individual fails the competency evaluation or the individual subsequently leaves employment.

(Source: Amended at 22 Ill. Reg. 10606, effective June 1, 1998)

Section 140.540 Costs Associated With Nursing Home Care Reform Act and Implementing Regulations

a) Facilities shall be reimbursed for reasonable expenses necessarily incurred to comply with regulations promulgated by the Department of Public Health pursuant to the Nursing Home Care Reform Act of 1979 (Ill. Rev. Stat. 1981, ch. 111 1/2, pars. 4151-101 et seq.). The estimates per patient, per day are as follows:

1)	License fees (Division 1, Section 2)	- $.004
2)	Resident advisory council (Division 3, Section 4)	- $.013
3)	Patient account management (Division 16, Section 6)	- $.023
4)	Denture Marking	- $.001
5)	Patient Identification	- $.001
	Total	- $.042

b) The reimbursement shall be based on the per diem cost estimate for the regulations of 4.2 cents, pro rated for the public aid share. The public aid share will be determined according to the number of public aid days in the facility between July 28, 1980 and December 31, 1981. The reimbursement for this time period will be included in the 1981 rate.

Section 140.541 Salaries Paid to Owners or Related Parties

a) Salaries (and other forms of compensation) paid to owners and related parties are allowable costs, subject to the following:

1) A figure for administrative salary costs paid to an owner is determined up to the following annual limits:

A) the 90th percentile of updated salaries paid to non-owner administrators for homes of that size and location group;

B) $50,000 for full time work (at least 35 hours per week) for one person performing management services for more than one home (in such cases, the salary costs used as the basis for comparison to the $50,000 limit will be those salary costs reported on the individual facility cost reports which are being used to set the rate for that year).

C) $50,000 for full time work (at least 35 hours per week) or a percentage thereof for part time work.

2) A figure for salary costs per facility paid to an administrator and all owners and their related parties performing an administrative function is determined up to an amount of two times the 75th percentile of updated salaries paid to non-owner administrators for homes of that size and location group.

3) The ceiling for allowable costs is the lesser of the amount determined under subsections (1) or (2) above.

b) The ceiling for allowable salary costs other than administrative shall be 130% of the average wage rate for those services based on the prior year's cost reports.

(Source: Amended at 8 Ill. Reg. 23218, effective November 20, 1984)

Section 140.542 Cost Reports-Filing Requirements

Long term care (SNF/ICF) and residential (ICF/MR) facilities, and developmental training (DT) programs shall file cost reports with the Department of Public Aid in accordance with the following requirements:

a) All schedules contained in the cost reports must be completed with the exception of those schedules specified in the cost report instructions as optional. Substitution of cost report schedules with provider records or other documents may not be made without written prior approval from the Department. Approval will be granted if the provider's documents contain the same information as the cost report schedule and the provider is not and does not anticipate serving public aid clients.

b) The cost report is not complete until all required schedules are filed and all inquiries to the provider are satisfactorily resolved. A provider will be notified by the Department in writing when the cost report is complete.

c) If the cost report is prepared by other than the provider's administrator or officer, the certification must be signed by the preparer as well as the officer or administrator. The preparer's declaration is based upon all information of which the preparer has any knowledge.

d) All financial data contained in the cost report must be accounted for on the accrual basis of accounting, except that governmental institutions operating on a cash method of accounting may submit data based on such a method.

e) Once a cost report has been correctly filed, no changes for the purpose of maximizing reimbursement shall be permitted. For example, it is not allowable to capitalize items which had been expensed on the cost report (or vice versa) unless the original method was clearly inconsistent with instructions for completion of cost reports and the Department has mandated the change.

(Source: Amended at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.543 Time Standards for Filing Cost Reports

a) Except as provided in subsections (b) and (c) below, the cost report must be filed within 90 days of the end of the fiscal year of long term care (ICF/SNF) and residential (ICF/MR) facilities and developmental training (DT) agencies. One extension up to 30 days shall be granted for circumstances which will not allow a cost report to be properly completed before the due date of the report. The written request for an extension must be submitted to the Department of Public Aid (DPA) Office of Health Finance prior to the original due date. All requests shall be judged based upon the individual circumstances to determine the length of the extension.

b) Change of Ownership – The new owner or lessee must file a cost report 9 months after acquisition (covering the first 6 months of operation). A change of ownership is dated from the closing of the sale or from the date of the oldest lease agreement between the present incumbents of a lease. The facility must also file a cost report within 90 days of the close of its first complete fiscal year.

    1) A change of corporate stock ownership does not constitute a change in ownership.

    2) The Department will not recognize any subsequent transaction by the lessee as a new acquisition for purposes of capital reimbursement. Capital costs are allowed only when a facility is constructed, sold or leased for the first time. The Department will recognize the one lease as a new acquisition.

c) New Facility – A long term care or residential facility which is licensed for the first time must file a projection of capital costs before any warrants will be released to the facility. A full cost report must be filed within 9 months after opening the facility (covering at least the first 6 months of operation). The facility must also file a cost report within 90 days of the close of its first complete fiscal year.

d) A set of small scale residential facilities licensed as ICF/DD-4 or ICF/DD-6, as defined in Section 140.561(b), shall file one combined cost report that covers each facility in the set. The section of the cost report pertaining to fixed asset cost and depreciation must be prepared separately for each licensed facility. The fixed asset section of the cost report must be completed with data combined for each licensed facility in the set.

(Source: Amended at 16 Ill. Reg. 12186, effective July 24, 1992)

Section 140.544 Access to Cost Reports (Repealed)

(Source: Repealed at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.545 Penalty for Failure to File Cost Reports

No funds shall be expended by the Department (DPA) for the maintenance of any resident in a long term care of residential facility which has failed to file an annual cost report. No funds shall be expended by the Department for developmental training (DT) services provided by any DT program which has failed to file an annual cost report.

(Source: Amended at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.550 Update of Operating Costs

The reported, allowable operating costs will be updated on a facility by facility basis for inflation experienced since this cost report was filed and for inflation anticipated during the rate year pursuant to Sections 140.551 through 140.555.

Section 140.551 General Service Costs Updates

General Service costs (hotel costs – food, dietary, laundry, utilities, maintenance – see Section 140.531) shall be updated by using nationally published indices specific to nursing home costs. (Health Care Cost Review, a publication of the Cost Information Forecasting Service, published quarterly by DRI-WEFA, Inc., a Global Insight Company, 24 Hartwell Avenue, Lexington, Massachusetts 02421 (2001). This incorporation by reference does not include any later amendments or editions.)

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.552 Nursing and Program Costs

Beginning July 1, 1991, nursing and program costs (mostly salary costs for direct care staff, but also including some supplies and other related expenses, see Section 140.532) will be updated by DRI average hourly earnings production workers for nursing and personal care facilities.

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.553 General Administrative Costs Updates

General Administrative costs (see Section 140.533) shall be updated by using nationally published indices specific to nursing home costs. (Health Care Cost Review, a publication of the Cost Information Forecasting Service, published quarterly by DRI-WEFA, Inc., a Global Insight Company, 24 Hartwell Avenue, Lexington, Massachusetts 02421 (2001). This incorporation by reference does not include any later amendments or editions.) Prior to any updating, fringe benefits and payroll taxes will be prorated to General Service and Program areas on the basis of salaries paid in those areas. (The prorated amount will be updated at the same rate as the other portions of those cost centers.)

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.554 Component Inflation Index (Repealed)

(Source: Repealed at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.555 Minimum Wage

In the event of minimum wage increases, it may be necessary to make further adjustments when the legislatively mandated change has an impact greater than the increase in costs projected by used of the above inflation projections. The specific adjustment for this change will be calculated as follows:

a) The average nurses' aide salary for each geographic area will be updated for inflation as specified in Section 140.552.

b) The number will be compared to the new hourly minimum wage figure plus ten cents.

c) If the minimum wage plus ten cents is less than the updated average nurses' aide salary, no adjustment will be made. If it exceeds the updated, average nurses' aide salary, the difference between the two will be divided by the updated nurses' aide salary. That will yield a percentage shortfall which will be adjusted by the statewide average of nonadministrative salary costs as a percentage of total operating costs and applied as an additional inflation factor to all facilities in that geographic area.

(Source: Amended at 20 Ill. Reg. 14845, effective October 31, 1996)

Section 140.560 Components of the Base Rate Determination

Except as specified otherwise in this Section, rates calculated for the rate year beginning July 1, 1990 and for subsequent years thereafter shall be based on the facility's cost report for the facility's full fiscal year ending at any point in time during the previous calendar year as long as that cost report is filed prior to April 1. Otherwise, the latest cost report available on March 31 will be used to set rates for July 1. For example, if a facility with a December 31, 1989 year end files their cost report prior to April 1, 1990, that cost report will be used to set rates for the rate year to begin on July 1, 1990. In this example, if the December 31, 1989 cost report is not filed until after March 31, 1990, the December 31, 1988 cost report will be used to set rates for the rate year to begin on July 1, 1990.

a) In the case of a change in ownership of a previously certified facility, the rate issued to the previous owner will be in effect for the remainder of the rate year. A new rate will be calculated for the next rate year based on the new owner's cost report if a cost report covering a minimum of the first six months of operation is received by the Bureau of Health Finance prior to April 1st. If a cost report covering the first six or more months of operation for the new owner cannot be filed with the Bureau of Health Finance prior to April 1st, the rate will be calculated based upon the prior owner's cost report filed in accordance with the opening paragraph of this Section. A cost report that has not been completed in accordance with the Department's rules and cost report instructions will not be considered as received until all cost report pages are properly completed.

b) In the case of a new facility, capital reimbursement will be assigned on the receipt of the first cost report (which may be an abbreviated cost report). The support reimbursement will be set at the median for that region. The facility must then file a six-month cost report (beginning with the date the first patient was admitted) that contains actual historical cost information. The capital and support rates will then be recalculated based upon this cost report. Rates so calculated will become effective on the first day of the first month after the six-month cost report is received by the Department's Bureau of Health Finance. The facility must obtain written verification of the initial cost reporting periods from the Bureau of Health Finance.

c) When a construction addition to the building will increase the licensed bed capacity by ten percent or more, the facility may file a revised cost report reflecting the increased capital investment. If this revised cost report is filed within 30 days after the date of the increase in licensure as determined by the Illinois Department of Public Health, any increase in the capital rate will be effective on the effective date of licensure increase. If the revised cost report is filed more than 30 days after the effective date of increase in licensure, any

increase in the capital rate will be effective on the first day of the first month after the report is received by the Bureau of Health Finance.

d) Once a rate for an individual facility has been calculated, a new rate will not be calculated during the course of the rate year except as provided in subsections (b) and (c) of this Section.

e) If a facility incurs building construction improvements that increase the total building cost for the current owner by ten percent or more and that would raise the base year, then the nursing home may file a revised cost report that reports the increased capital investment. Only facility building construction improvements completed after the end of the period of the report used to calculate the last capital rate calculation can be used to meet the ten percent requirement. Purchases of buildings for use by the facility and allocations of central office buildings and improvements cannot be used to meet the ten percent requirement. The base year is defined in Section 140.570(b)(2). If the improvements have been completed and put into use prior to the forthcoming rate year and the cost report reflecting increased capital costs is filed prior to the beginning of the next rate year, then any increase in the capital rate will be effective on the first day of the rate year.

f) In order to accommodate the downsizing to close or reduce bed capacity of ICF/MR facilities licensed for ICF/DD or SNF/PED Services, the following provisions will apply. These provisions only apply for facilities with 17 or more licensed beds that decrease their total licensed beds by 20 percent or more due to a decrease in the beds licensed as ICF/DD or SNF/PED. The reduced bed capacity must be necessary to achieve one or more of the following goals: achieve compliance with ICF/MR regulations, such as four or fewer persons per room; achieve compliance with ICF/MR regulations in an adverse action as part of a Plan of Correction (see the Department of Public Health rules at 77 Ill. Adm. Code 300.278); increase available space in order to provide active treatment services to residents; and permit the voluntary closure of a facility in order to achieve community placement to settings of size eight or fewer residents, provided sufficient funds are available to the Department of Human Services (DHS).

1) The facility must request pre-approval for application of these provisions from the DHS Director of the Division of Disability and Behavioral Health Services (DDBHS). The written request must describe the necessity to reduce licensed bed capacity. The facility must submit a proposed timetable for the downsizing, including the projected dates of each decrease in census and the census on that date (the benchmark). Written approval may be granted if DHS determines the change will be

beneficial for the ICF/DD or SNF/PED residents. If approval is granted, DHS will enter into a downsizing agreement with the facility with provisions including the downsizing plan, benchmarks, rate adjustments and items of compliance regarding the safety and placement of residents.

2) The reduction in the number of licensed beds must be completed within a one-year period following the DDBHS Director's approval, unless a longer reduction period is approved by the Deputy Director at the onset of the plan. Not fewer than 90 days prior to the projected end date of the downsizing plan, the facility must make application to the Department of Public Health (DPH) for a formal licensure change to reflect the number of licensed beds, if any, to remain at the conclusion of the downsizing plan. The effective date of the licensed bed change will be the actual date the final resident benchmark census objective is reached.

3) A facility is ineligible for downsizing if the facility has been notified in writing by DPH of a need for a Plan of Correction for non-compliance with conditions of participation, Type A violations, licensure non-compliance, or because the facility has been declared an "immediate and serious threat" to the welfare of any resident or residents in the one-year period preceding the date of a request for application of these downsizing provisions unless the DDBHS Director has granted the facility a waiver of this one year requirement.

4) When DPH notifies a facility in writing of a need for a Plan of Correction for non-compliance with conditions of participation, Type A violations, licensure non-compliance, or because the facility has been declared an "immediate and serious threat" to the welfare of any resident, the facility may seek DHS approval of a downsizing plan concurrently as part of a Plan of Correction to DPH in accordance with the time frames and process allotted by DPH. If a downsize application is not made at this time and as part of a Plan of Correction, the facility is ineligible for downsizing.

5) During the downsizing period, the facility may not accept any admissions except with explicit permission of DHS. The facility must agree to make every effort to insure immediate notification (within 72 hours) to DHS and to the local DHS office of all changes in recipient enrollment, eligibility, income, assets, earnings and other status. The facility must agree to make available to DHS and interested parties such records as necessary to disclose the type and quantity of care provided to specific residents, as well as physicians' reports, need for care, level of functioning and orders for services. The facility must agree to provide access to resident care

records and facility records and policies concerning resident care throughout the downsizing period.

6) The capital and support rates in effect at the time of approval of the downsizing plan (exclusive of any flat add-on rate increases) will be modified for downsizing in accordance with subsection (f)(9) of this Section.

7) The capital and support rates will be revised with the achievement of the benchmarks specified in the downsizing agreement during the approved downsizing period.

A) The capital rate will be increased in proportion to the agreed on decrease in the census achieved at the end of each benchmark period from the census at the start of the downsizing period. For example, with an original census of 98 residents at the start of the downsizing period and the achievement of a reduction of eight residents to reach the benchmark of 90 residents, the initial $7.41 capital rate will be increased to $8.07 as follows: (the initial capital rate) is multiplied by (the original census that has been divided by the achieved census reduction), or ($7.41) X (98/90 or 1.089) = $8.07.

B) The support rate will be increased in proportion to the decrease in census achieved at the end of each benchmark period from the census at the start of the downsizing period, with the assumption that 50 percent of the support costs are fixed and 50 percent of the support rate is variable (for example, costs vary as the number of residents varies). The fixed half of the support rate will be increased in proportion to the achieved decrease at the end of each benchmark period. For example, with an original support rate of $22, the support rate would be [(.5 X $22) X (98/90)] + (.5 X $22) = $22.98.

C) The program rate will be set according to the methodology in DHS rules at 89 Ill. Adm. Code 144 (exclusive of any flat add-on increases).

8) The support rate for ICF/DD facilities may not exceed the facility's geographic area ceiling. Facilities having SNF/PED licenses, that are reducing facility census to comply with ICF/MR regulations that limit the number of persons per bedroom to four or fewer may exceed the facility's

geographic area ceiling but by no more than 125 percent. The exception allowing SNF/PED facilities to exceed the support rate geographic area ceiling will only be based on the reduction in census to attain four or fewer persons per bedroom. If a SNF/PED facility reduces census below that required to attain four persons per bedroom, the support rate may not exceed the facility's geographic area ceiling.

9) At the conclusion of the downsizing period the capital, support and program rates will be determined as follows:

A) The capital rate component will be fixed at the final downsizing rate and will remain in effect until such time as the rate methodology in effect produces a rate based on the downsized licensed capacity that surpasses the downsize capital rate amount. The final downsize capital rate will be increased by funding changes such as cost of living increases, when given. All space in the facility must continue to be used as an ICF/DD or SNF/PED. Use of the facility for an on-site developmental training program, school services or uses unrelated to the operation of the facility as an ICF/DD or SNF/PED, will require the calculation of the capital rate according to the methodology of Sections 140.570 through 140.574 after an adjustment of the facility's capital costs in proportion to the involved square footage. This capital rate will be effective the first day of the month following the change in space usage. Capital improvements to the downsized facility may be made and will be reimbursed as an increase to the downsize capital rate determined as the applicable percentage rate of return of the capital methodology times the per diem per bed reported amount of the improvement. The support rate in effect at the end of the downsizing period will remain in effect until a cost report covering the first six months of operation of the downsized facility is submitted as would be applicable to a new facility in accordance with provisions in subsection (b) of this Section. These six-month costs and the corresponding days of care will be used to set the support rate in accordance with the support component rate methodology in effect.

B) The program rate will be set according to the methodology described at 89 Ill. Adm. Code 144.

(Source: Expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006)

Section 140.561 Support Costs Components

Support Costs Components (includes laundry, dietary, housekeeping, utility and administrative expenses)

a) The Department shall reimburse each facility for support costs associated with the provision of long term care on the basis of the relationship between the facility's per diem allowable support costs and referent values determined for each geographic area from the distribution of per diem allowable support costs for all long term care facilities with adequate cost report data. For all facilities with a Department of Public Health license classification SNF/ICF (Skilled Nursing Facility, Intermediate Care Facility) or ICF/DD (Intermediate Care Facility for the Developmentally Disabled), the support rate will be computed as follows for the rate year to begin July 1, 1989, and subsequent years:

1) If a facility's per diem allowable support costs are less than the 35th percentile value for per diem allowable support costs in the geographic area, the support rate will be equal to the facility's per diem allowable support costs plus 50% of the difference between the 75th percentile value for per diem allowable support costs in the geographic area and the facility's per diem allowable support costs, up to a ceiling. The ceiling shall be equal to 50% of the difference between the 75th percentile value of allowable per diem support costs for the geographic area and the 35th percentile value of allowable per diem support costs for the geographic area plus $.05.

2) If a facility's per diem allowable support costs are greater than or equal to the 35th percentile value of per diem allowable support costs for the geographic area and less than the 75th percentile value of per diem allowable support costs for the geographic area, the support rate will be equal to the facility's per diem allowable support costs plus 50% of the difference between the 75th percentile value of per diem allowable support costs for the geographic area and the facility's per diem allowable support costs.

3) If a facility's per diem allowable support costs are equal to or greater than the 75th percentile value of per diem allowable support costs for the geographic area, the support rate will be equal to the 75th percentile value of per diem allowable support costs for the geographic area.

b) Small scale ICF/MR facilities which are licensed as Intermediate Care Facilities for the Developmentally Disabled with four or six beds (ICF/DD-4, ICF/DD-6)

(see 89 Ill. Adm. Code 144.300 and 144.325) are separately licensed facilities. However, for support reimbursement, the per diem is based on a sixteen person capacity and the sum of the support cost components is aggregated over four 4-person ICFs/DD, or one 4-person plus two 6-person ICFs/DD. The set of small scale ICFs/DD used in computing the support per diem will be identified in the provider agreements. All facilities in a set must be within the boundaries of the same geographic area. Removal and/or addition of a small scale ICF/DD which is part of a set requires both a written notice by the provider 90 days before the beginning of a fiscal year (July 1), or upon certification in the case of a new facility which is licensed, and a change in the affected provider agreement that identifies the membership of the set. Each per diem calculated by aggregating allowable support costs over the specified set of small scale ICFs/DD based on a sixteen person capacity will be treated as a single facility licensed as ICF/DD-16, and will be included in the computation of support rates described in subsection d).

c) For all facilities with a Department of Public Health license classification SNF/PED (Skilled Nursing Facility for Pediatric residents), the support rate will be computed exactly as described for the SNF/ICF and ICF/DD facilities, except that the referent value for each geographic area (i.e., the 35th percentile values and the 75th percentile values for per diem allowable support costs) will be increased to 120% of the referent values applied in the computation of the support rates for SNF/ICF and ICF/DD facilities.

d) For all facilities with a Department of Public Health license classification ICF/DD-16 (Intermediate Care Facility for the Developmentally Disabled with 16 or fewer residents or a set of small scale ICFs/DD with a sixteen person capacity), the support rate will be computed by regionalizing the 35th percentile values and the 75th percentile values for per diem allowable support costs based upon cost of facilities or sets of facilities licensed as ICF/DD-16. A set of facilities licensed as ICF/DD-4 or ICF/DD-6 are considered as an ICF/DD-16 for the purpose of support reimbursement and the support rate is computed exactly as described for ICF/DD-16 facilities. All ICFs/DD-16, including sets of ICF/DD-4 and/or ICF/DD-6 facilities, will be used to locate the 35th percentile and the 75th percentile values for per diem allowable support costs. Those sets of small scale facilities which have support costs above the 75th percentile will be reimbursed for supports costs up to, but not to exceed, 106.6% of the 75th percentile.

e) For all facilities with a Department of Public Health license classification SLC (Specialized Living Center), as determined by the Department of Mental Health and Developmental Disabilities and recognized by the Department of Public Aid, the support rate will be computed exactly as described for the SNF/ICF and

ICF/DD facilities, except that the referent values for each geographic area (i.e., the 35th percentile values and the 75th percentile values for per diem allowable support costs) will be increased to 152.8% of the referent values applied in the computation of the support rates for SNF/ICF and ICF/DD facilities.

(Source: Amended at 20 Ill. Reg. 14845, effective October 31, 1996)

Section 140.562 Nursing Costs

a) The Department reimburses for nursing costs based on geographic area in which the facility is based, and the level of care the facility (or distinct part thereof) is licensed to provide. Nursing costs also include an increment to reimburse for patients requiring skilled care for differences in support cost areas statistically related to variable patient conditions. For residents in Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF), the Department reimburses for nursing costs according to Sections 140.900 through 140.907; for residents in Skilled Nursing Facilities for Pediatrics (SNF/PED) or Intermediate Care Facilities for the Medically Retarded (ICF/MR), the Department reimburses for nursing costs according to Sections 140.850 through 140.885.

b) For the period July 1, 1986, through December 31, 1986, no facility's rate of reimbursement for Nursing Services shall be less than 90% of the rate of reimbursement for Nursing Services that facility received for the period January 1, 1986, through June 30, 1986.

c) For the period July 1, 1986 through December 31, 1986, the Department shall perform an additional computation for the rate of reimbursement for Nursing Services.

1) For intermediate and skilled care facilities, the additional computation is as follows:

A) Unadjusted nursing rates will be computed according to Section 140.905.

B) The unadjusted nursing rate will be compared to 90 percent of the previous effective rate for Nursing Services for each facility. The greater of the two rates will be the "hold harmless" nursing rate.

C) The mean difference between the "hold harmless" nursing rates and the previous effective nursing rates will be computed for each HSA area. This difference will be an interim base for the HSA area.

D) The adjusted nursing rate will be the sum of the "hold harmless" nursing rate and the interim base rate.

2) For intermediate and skilled care facilities for the developmentally disabled, the additional computation is as follows:

A) Unadjusted nursing rates will be computed according to Section 140.885.

B) The mean difference between the unadjusted nursing rates and the previous effective nursing rates will be computed for each licensure group. This difference will be an interim base rate for the licensure group.

C) The adjusted nursing rate will be the sum of the unadjusted nursing rate and the interim base rate.

d) For the period January 1, 1987 through June 30, 1987, the nursing rate component for any skilled and intermediate care facility (not including facilities for the developmentally disabled) will be the higher of either the rate for the prior rate period (July 1, 1986 through December 31, 1986) or the rate as calculated according to Subpart G.

e) For the period January 1, 1987 through June 30, 1987, the nursing rate component for facilities for the developmentally disabled will be the same as for the prior rate period (July 1, 1986 through December 31, 1986).

f) For the period July 1, 1987, through December 31, 1987, the nursing rate component (updated for wage inflation from January 1, 1987, through January 1, 1988, as computed in Sections 140.909(b)(1)(A)(iv) and (v)) for long term care facilities for the developmentally disabled will be the same as for the prior rate period (January 1, 1987, through June 30, 1987).

g) For the period January 1, 1988 through June 30, 1988, the nursing rate component for facilities for the developmentally disabled will be the same as for the prior rate period (July 1, 1987 through December 31, 1987).

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.563 Capital Costs

The Department reimburses for capital costs on a group basis related to location and base year. Effective for the rate year beginning July 1, 1984, a base year is defined as follows:

a) For facilities built or purchased prior to January 1, 1978, the later of year of construction or year of purchase;

b) For facilities built January 1, 1978, or later, the year of construction;

c) For facilities purchased on or after January 1, 1978, the base year established under (a) above will not change.

(Source: Amended at 9 Ill. Reg. 2697, effective February 22, 1985)

Section 140.565 Kosher Kitchen Reimbursement

Effective July 1, 1991, for reimbursement to skilled and intermediate care facilities with rabbinically approved or certified fully kosher kitchen and food service operations, the Department will determine eligibility according to the following procedures:

a) Qualified Providers
The facility must have a fully kosher kitchen and food service operation that is, at least annually, rabbinically approved or certified and sixty percent (60%) or more of the residents in the facility request kosher foods or food products prepared in accordance with Jewish religious dietary requirements.

b) Enrollment

1) The facility must notify the Department, in writing, of its request to be considered for kosher kitchen reimbursement.

2) Department staff may visit the facility to determine that the facility has a fully kosher kitchen and that at least sixty percent (60%) of its residents are requesting kosher foods or products.

3) The facility will be required to supply a list to the Department of current residents and identify which residents request kosher foods or products and sign a form certifying that the percentage of residents requesting kosher foods or products is at least sixty percent (60%). The rabbi will be required to sign the same form certifying that the fully kosher kitchen is rabbinically approved or certified at least annually.

4) Upon receipt of the certification form, the additional reimbursement will be added to the support component of the facility per diem rate and will become effective on the first day of the month subsequent to the month the facility request was received. The support rate ceiling established in Section 140.561(a)(1) may be exceeded as a result of this kosher kitchen rate factor.

5) The facility must notify the Department of any change in the percentage of residents requesting kosher foods or products if that number drops below the required sixty percent (60%). Upon notification, the Department will adjust the support component of the facility per diem accordingly.

6) Annually, the facility must complete the certification form and submit it to the Department with their cost report.

c) Reimbursement
Based upon food cost reports of the Illinois Department of Agriculture regarding kosher and non-kosher food available in the various regions of the State, the rate structure may be periodically adjusted by the Department but may not exceed the maximum amount authorized under Public Act 86-1464.

(Source: Section repealed at 14 Ill. Reg. 7141, effective April 27, 1990; new Section adopted at 16 Ill. Reg. 12186, effective July 24, 1992)

Section 140.566 Out-of-State Placement

Residents of Illinois who have been determined as requiring long term care placement should be placed in an Illinois facility.

a) The Department of Public Aid (DPA) or the Department of Mental Health and Developmental Disabilities (DMHDD) may make payment for care of a client in an out-of-state facility if:

1) the client is a resident of Illinois in accordance with DPA residency requirements, and

2) placement within Illinois cannot be obtained, and

3) prior approval has been given by the agency which will fund the placement, whether DPA or DMHDD, or the funding agency's designee.

b) Payment to out-of-state facilities will be negotiated based on the intensity of the services required, and will take into consideration:

1) the rate for medical assistance clients requiring the same level of care that is paid by the state in which the facility is located, and

2) the private pay rate in the facility, and

3) the Illinois Statewide average rate for medical assistance clients requiring a similar level of care.

c) Payment cannot be approved for clients who made their own arrangements for care in facilities in other states if an appropriate bed is available in Illinois.

d) Payment cannot be approved if a client or the family prefers placement in an out-of-state facility in order to stay near the home community, or near to family or for other personal reasons.

e) Annually, placement of a client in an out-of-state facility will be re-evaluated to ensure placement is still appropriate.

f) Payment for care in an out-of-state facility may be approved for a client who becomes ill while temporarily out of Illinois.

(Source: Amended at 20 Ill. Reg. 14845, effective October 31, 1996)

Section 140.567 Level II Incentive Payments (Repealed)

(Source: Repealed at 14 Ill. Reg. 7141, effective April 27, 1990)

Section 140.568 Duration of Incentive Payments (Repealed)

(Source: Repealed at 14 Ill. Reg. 7141, effective April 27, 1990)

Section 140.569 Clients With Exceptional Care Needs

a) Exceptional Care Program

1) Effective January 1, 2007, exceptional care services shall be covered under the MDS-based reimbursement methodology as described in 89 Ill. Adm. Code 147.Table A. As long as the nursing facility's case mix, as determined by total minutes from 89 Ill. Adm. Code 147.Table A, does not decrease in excess of five percent when compared to the case mix as of June 30, 2006, exceptional care reimbursement shall be converted to a per diem computed as the sum of all exceptional care daily payments less the residential rate made to the facility on June 30, 2006 divided by the total number of residents that are paid nursing and exceptional care rates as of June 30, 2006. No new residents will be accepted into the Exceptional Care Program after December 31, 2006. All facility exceptional care contracts will be terminated December 31, 2006. The provisions of this Section governing the Exceptional Care Program remain in place through December 31, 2006.

2) Pursuant to Section 5-5.8a of the Illinois Public Aid Code [305 ILCS 5/5-5.8a], the Department may make payments for exceptional care services to nursing facilities ("providers") that meet licensure and certification requirements as may be prescribed by the Department of Public Health and are enrolled in and meet participation requirements of the Medical Assistance Program pursuant to Sections 140.11 and 140.12.

3) Exceptional medical care is defined as the level of care with extraordinary costs related to services which may include physician, nurse, ancillary specialist services, and medical equipment and/or supplies that have been determined to be a medical necessity. This shall apply to Medicaid patients who are being discharged from the hospital or other setting where Medicaid reimbursement is at a rate higher than the exceptional care rate for related services or to persons who are in need of exceptional care services who would otherwise be in an alternative setting at a higher cost to the Department and Medicaid eligible residents transitioning from Medicare to Medicaid while in the nursing facility. This includes but is not limited to head-injured persons, ventilator dependent persons or persons with HIV/AIDS.

4) The Department shall negotiate rates with facilities requesting payment for exceptional care services (see Section 5-5.8a of the Public Aid Code [305 ILCS 5/5-5.8a]). In determining the rates of payment, the Department

shall consider data collected from exceptional care providers during fiscal year 1994, any intervening rate adjustments (including any updates for inflation) and the average cost of each service category for the geographic area in which the facility is located. After approval of negotiated rates, the Department shall annually update a facility's rates for inflation.

b) Exceptional Care Requirements
The Department may enter into agreements with providers for the provision of exceptional care services only if the provider agrees to the following terms:

1) The provider will maintain separate records regarding costs related to the care of the exceptional care residents.

2) The provider must demonstrate the capacity and capability to provide exceptional care as documented by Department of Public Health and Department of Healthcare and Family Services records, including, but not limited to, being free of finalized Department of Public Health findings (exhaustion of appeals process with deficiencies remaining) after January 1, 1997, that the provider has deficiencies related to substandard quality of care during the period of time since the last standard certification survey or imposition of a conditional license.

3) The provider must maintain and provide documentation demonstrating:

A) Adherence to staffing requirements as set out in subsection (c) of this Section;

B) Adherence to staff training requirements as set out in subsection (d) of this Section;

C) Validity of written agreements as required in subsection (e) of this Section;

D) Presence of emergency policy and procedures as set out in subsection (f) of this Section;

E) Medical condition of the resident; and

F) Care, treatments and services provided to the resident.

4) The provider must have and maintain physical plant adaptations to accommodate the necessary equipment, such as an emergency electrical

backup system.

c) Exceptional Care Staffing Requirements
Staffing requirements for providers of exceptional care include:

1) A minimum of one RN on duty on the day shift, seven days per week (as required by the Department of Public Health in 77 Ill. Adm. Code 300.1240 or 250.910(e) and (f)(1) as appropriate). Additional RN staff may be determined necessary by the Department of Healthcare and Family Services, based on the Department's review of the exceptional care services needs;

2) A minimum of the required number of LPN staff (as required by the Department of Public Health in 77 Ill. Adm. Code 300.1230 and 300.1240 or 250.910(e) and (f)(1) as appropriate), on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week; and

3) For those providers of complex respiratory or ventilator services under the exceptional care program, a certified respiratory therapy technician or registered respiratory therapist, on staff or on contract with the provider.

d) Training Requirements for Providers of Exceptional Care for Ventilator Dependent Residents

1) At least one of the full-time professional nursing staff members must have successfully completed a course in the care of ventilator dependent individuals and the use of ventilators, conducted and documented by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one year experience in the care of ventilator dependent persons.

2) All staff caring for ventilator dependent residents must have documented inservice training in ventilator care prior to providing such care. Inservice training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one year experience in the care of ventilator dependent persons. Inservice training documentation shall include name and qualification of the inservice director, duration of presentation, content of presentation and signature and position description of all participants.

e) Exceptional Care Agreement Requirements

The provider must have a valid written agreement with:

1) A medical equipment and supply provider which must include a service contract for ventilator equipment when accepting ventilator dependent residents;

2) A local emergency transportation provider;

3) A local hospital capable of providing the necessary care for equipment dependent residents, when appropriate; and

4) A certified respiratory therapy technician or registered respiratory therapist (unless a respiratory therapist is on staff within the facility), when accepting ventilator dependent residents or residents requiring respiratory therapy services.

f) Exceptional Care Emergency Policy and Procedures Requirements
The provider must have specific written policies and procedures addressing emergency needs for residents requiring exceptional care.

g) Accessibility to Records
The provider must make accessible to HFS and/or IDPH all provider, resident and other records necessary to determine that the needs of the resident are being met and to determine the appropriateness of exceptional care services.

h) Provider Approval Process

1) A provider shall notify the Department, in writing, of its interest in participating in the Exceptional Care Program.

2) If approved by the Department, a written exceptional care agreement with the provider shall be executed. Such agreements are separate and distinct from the provider agreements specified in Section 140.11(a)(6) and are not subject to the provisions regarding notice and right to hearing in the event of termination specified in 89 Ill. Adm. Code 104.208 and 104.210.

3) Providers desiring to discontinue providing exceptional care shall notify the Department, in writing, at least 60 days prior to the date of termination. Payment for exceptional care residents already residing in facilities which notify the Department that they wish to discontinue providing exceptional care services will remain at the previous exceptional care rate as long as the resident meets exceptional care criteria and as long

as all related criteria are met by the provider as determined by the Department's utilization review (see Monitoring, subsections (k)(2) and (3) of this Section) or the resident is discharged.

4) It is the responsibility of the provider to effect appropriate discharge planning for exceptional care residents when terminating services for exceptional care. The Department agrees to assist providers with any information available regarding appropriate placement settings.

5) The Department may terminate a provider's agreement, for any reason, upon 60 days written notice to the provider. Reasons for which the Department may terminate an agreement include, but are not limited to, Department of Public Health findings that the provider has deficiencies related to substandard quality of care or imposition of a conditional license.

i) Determining Eligibility for Exceptional Care Payment

1) A person being discharged from a hospital or those who are in another setting must be approved by an authorized Department representative prior to placement in a facility to be eligible for exceptional care payment.

2) In order for a person to be approved for exceptional care reimbursement, the cost of the person's care must be at least 50% more than the proposed admitting provider's Medicaid per diem rate (capital, support and nursing components). Eligible items that may be used in computing the cost of the resident's care include nursing services costs, therapy services costs, and medical equipment and supply costs. Computations for determining cost of care shall be based upon costs for services, medical equipment and supplies for the proposed admitting provider as determined by the Department.

j) Provision for Hospital Patients for which a Long Term Care Placement is Unavailable

In the event placement for a patient in need of exceptional care services or skilled nursing services cannot be located, the Department shall approve payment to the hospital in which the patient is receiving services at a rate not to exceed the average Statewide long term care provider per diem for the level of services provided.

k) Monitoring

1) All utilization controls applied to exceptional care by the Department in accordance with the approved plan for medical services under the Illinois Public Aid Code [305 ILCS 5/5-2], and Title XIX of the Federal Social Security Act (42 USC 1396a) shall continue to apply to exceptional care provided under the Exceptional Care Program described in the Health Finance Reform Act [20 ILCS 2215/3-5].

2) The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with Medical Peer Review organizations to provide utilization review and quality assurance.

3) The Department shall review exceptional care residents' utilization of services every 90 days. A review may be waived by the Department if one or more previous assessments show that a resident's condition has stabilized. However, two consecutive reviews shall not be waived. Department staff will maintain contact with the long term care provider regarding the resident's condition during the time period any assessment is waived.

4) In the event that it is determined that the resident is no longer in need of or receiving exceptional care services, the Department shall discontinue the exceptional care payment rate for the resident and reduce the rate of payment to the provider to the provider's standard Medicaid per diem rate.

(Source: Expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006)

Section 140.570 Capital Rate Component Determination

a) Capital rates for all long term care facilities – except State Institutions, Specialized Living Centers and campus facilities, shall be reimbursed in the manner described in Sections 140.570 through 140.573. Capital rates for Specialized Living Centers are set forth in 140.579. Campus facilities are reimbursed in accordance with 140.583.

b) The terms used in Sections 140.570 through 140.574 are defined as follows.

1) "Arm's-length transaction" means a transaction between a buyer and a seller both free to act, each seeking his own best economic interest. A transaction between related parties as defined in Section 140.537 is not considered to be an arm's-length transaction.

2) "Base Year" refers to the weighted average year of investment in the actual construction of the building. The Base Year is determined using the components of the building cost, which are included in the Original Building Base Cost, and the corresponding years of acquisition or construction. The year of each component of the total investment is multiplied by the cost of each year's investment. The sum of these products is then divided by the total Original Building Base Cost to yield an average year of construction. Any fractional portion of the Base Year derived from this calculation will be truncated. The Base Year will not change due to sale or lease of the building subsequent to January 1, 1978.

3) "Capital Days" are used to convert all capital items to per diem amounts unless otherwise specified. If a facility's occupancy rate is above 93 percent, then capital days shall be equal to the actual patient days. If occupancy is below 93 percent, then 93 percent of available bed days (the number of licensed beds multiplied by the number of calendar days in a period) shall be the capital days.

4) Building Basis:

A) "Original Building Base Cost" means either the cost of construction or the cost of the latest purchase of the building in an arm's-length transaction prior to January 1, 1978. The allowable cost of subsequent improvements to the building will be included in the original building base cost. The original building base cost will not change due to sales or leases of the facility after January 1, 1978. In the case of a nursing home building constructed after

January 1, 1978, the allowable construction cost plus the cost of subsequent improvements will be the original building base cost.

B) If a portion of the building is vacant or is used for functions other than a nursing home, then a portion of the building's original building base cost will not be used in the rate calculation. This cost allocation will be based upon the proportion of the total square feet in the building being used for nursing home functions.

5) "Rate of Return" will be 11.0 percent for base years which are 1979 and later and 9.13 percent for base years which are 1978 and earlier.

6) "Means Construction Index" means the index of changes in construction costs from year-to-year developed from the annual publication Means Building Construction Cost data as published by R.S. Means Company, Inc.

7) "Means New Construction Cost Per Square Foot" is defined as the costs published by the R.S. Means Company, Inc. Data will come from the most recent edition of the Means Square Foot Costs publication. The cost used per square foot for new construction is based upon nursing home construction projections using 40,000 square foot category with face brick with concrete block back-up and steel joists. The Means New Construction Cost Per Square Foot will be adjusted where necessary to ensure an increase of at least a three percent from the previous year but no more than a seven percent increase.

8) "Square Feet Per Bed" is defined as 316 square feet per bed. This was the average for existing long term care facilities in Illinois.

9) "Location". The long term care facilities will be separated into one of the following areas:

Northeast area – HSAs 6, 7, 8, 9

Downstate area – HSAs 1, 2, 3, 4, 5, 10, 11

10) "Uniform Building Value" is calculated using the following steps:

A) The Means New Construction Cost Per Square Foot is multiplied by 316 square feet per bed to obtain a preliminary cost per bed. For example, $68.65 cost per square foot times 316 equals a

$21,693 preliminary cost per bed.

B) The preliminary cost per bed is multiplied by an adjustment factor to obtain the revised cost per bed for new construction. The adjustment factor is 1.30 for the northeast area and 1.19 for the downstate area. For example, a $21,693 preliminary cost per bed times the 1.30 factor equals a $28,200 revised cost per bed for the northeast area.

C) The revised cost per bed for new construction will be the uniform building value for any facility for which the base year is the same as the current year. The current year is the calendar year in which the rate year starts. The uniform building value for facilities with a base year which is older than the current year will have the revised cost per bed for new construction discounted by a three percent obsolescence factor for each year between the base year and the current year. The uniform building value will be no lower than ten percent of the revised cost per bed for new construction. For example:

Base Year	Factor	Uniform Building Value
1991	100%	$28,200
1990	97%	$27,354
1989	94%	$26,508
1988	91%	$25,662
1987	88%	$24,816
1986	85%	$23,970

1975	52%	$14,664

1960	10%	$ 2,820

11) "Building Specific Historical Cost Per Bed" is the inflated original building base cost divided by the number of licensed beds on the cost report used to calculate rates for the rate year. If licensed beds changed during the cost report period, the licensed beds on the last day of the cost report period will be used as the devisor. The original building base cost is inflated based upon the Means Construction Index and the base year.

12) The "ERVWC" factor relates to equipment, rent, vehicle and working capital cost. The ERVWC factor will be the greater of $1.75 per diem or the amount from the following calculation based upon a sample of 50

percent or more of all long term care facilities:

A) Working Capital: Allowable support costs, nursing or program costs and administrative costs will be updated for inflation and be divided by Capital days and multiplied by 60 days to yield two months of Working Capital investment on a per diem basis.

B) The per diem investment in equipment and vehicle will be added to the working capital investment on a per diem basis (the vehicle investment is limited to fifty cents per diem). This total investment is multiplied by 9.13 percent.

C) The result of Step B is added to the per diem equipment rent cost to obtain an ERVWC base factor.

c) Any items of fixed equipment which are no longer in use or are not providing significant value for inpatient long term care purposes must not be reported on the cost report fixed asset schedules for land, buildings, equipment and vehicle. For example, portions of a building not being used for nursing home operations must not be reported. Any assets which were removed from the cost report depreciation schedules prior to the 1986 cost report due to the asset being fully depreciated may not now be included in the building or equipment basis. Also, if a vehicle is used partially for personal purposes or purposes other than operation of the nursing home then this portion of the cost must not be included in the vehicle cost section of the cost report.

d) No asset may be included in the building or equipment basis unless complete documentation for the cost and year of purchase or construction is maintained. This data must be maintained to facilitate efficient audit reviews by representatives of the Department.

(Source: Amended at 20 Ill. Reg. 6929, effective May 6, 1996)

Section 140.571 Capital Rate Calculation

a) Determination of Blended Value

1) The capital rate will be calculated through a blending of:

A) the uniform building value and

B) the building specific historical cost per bed.

2) If the building specific historical cost per bed (B) is less than the uniform building value (A), the blended value will be one-half of the difference between (A) and (B) added to (B) the building specific historical cost per bed. For example, if (b) is $16,0000 and (A) is $20,000, the blended value will be $18,000.

3) If the building specific historical cost per bed (B) is greater than the uniform building value (A), the blended value will be one-half of the difference between (A) and (B) added to (A) the uniform building value. In this situation, the blended value will be limited to 120% of the uniform building value (A). For example, if (B) is $28,000 and (A) is $16,000, the blended value will be $19,200.

b) Rate Calculation

1) The blended value will be divided by 339 days. (The 339 days is 365 days times a 93% occupancy standard.)

2) The per diem value will be multiplied by the rate of return to obtain a building rate factor.

3) The ERVWC factor will be added to the building rate factor to obtain the preliminary capital rate.

4) The capital rate will be the greater of the preliminary capital rate from 3) or an implementation capital rate which is 115% of the FY'91 capital rate paid to the same licensed provider.

(Source: Amended at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.572 Total Capital Rate

The total capital rate will be the rate from Section 140.571(b)(4), plus the property tax rate from Section 140.578(b).

(Source: Amended at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.573 Other Capital Provisions

a) If at the time of field audit, the auditors find that the records to support capital costs are not adequate to issue an unqualified opinion, that facility's capital reimbursement will not be allowed to exceed the rate calculated from use of the uniform building value. The 120% blending factor in Section 140.571(a)(3) will not be allowed.

b) For any change of ownership after July 18, 1984, the cost basis of any asset shall be the lesser of the allowable acquisition cost of such asset of the first owner of record on or after July 18, 1984, or the acquisition cost of such asset to the new owner.

(Source: Amended at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.574 Capital Rates for Rented Facilities

Capital rates for facilities rented pursuant to arms-length transactions shall be reimbursed in the following manner:

a) Facilities which have been rented on or after January 1, 1978 will have their capital rate calculated in accordance with Sections 140.570, 140.571 and 140.572.

b) Facilities which have been rented continuously from an unrelated party since prior to January 1, 1978 or since the first day of operation for facilities constructed January 1, 1978 or later will not have a blended value calculated. The uniform building value will be substituted for the blended value in Section 140.571(a)(1).

c) The base year for facilities rented prior to January 1, 1978, will be the year of the initial rental agreement for the nursing home operator in existence on December 31, 1977. Purchase or lease on or after January 1, 1978, will not change the base year for the facility. If the building was owned prior to January 1, 1978, and was subsequently rented, the base year will be determined based upon provisions in Section 140.570(b)(2).

(Source: Amended at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.575 Newly Constructed Facilities (Repealed)

(Source: Repealed at 11 Ill. Reg. 12011, effective June 30, 1987)

Section 140.576 Renovations (Repealed)

(Source: Repealed at 10 Ill. Reg. 672, effective January 6, 1986)

Section 140.577 Capital Costs for Rented Facilities (Renumbered)

(Source: Renumbered to Section 140.574 at 11 Ill. Reg. 12011, effective June 30, 1987)

Section 140.578 Property Taxes

a) For long term care services rendered from July 1, 1984, through June 30, 1985, each facility shall be reimbursed for property taxes at a rate equal to the reported per diem property tax adjusted for occupancy as specified in Section 140.570(b)(3) and projected forward to the mid-point of the rate year using the average yearly changes in property taxes as reported on the most recent available cost report for a sample of homes in the geographic area.

b) For long term care services rendered subsequent to June 30, 1985, the reimbursement for real estate taxes shall be based upon the actual taxes assessed for the base year. The base year will be the calendar year which ended 18 months before the beginning of the rate year on July 1. A per diem real estate tax will be determined using actual occupancy or adjusted occupancy as specified in Section 140.570(b)(3). This per diem cost will be projected forward to the mid-point of the rate year using the average yearly changes in property taxes for each geographic area based upon a 20 percent sample of facilities with property tax cost. Property taxes which do not relate to the provision of care in the nursing home, such as tax assessments for investment property, will not be considered for reimbursement.

1) Each year long term care facilities must submit a copy of the real estate tax bills to the Department. The Department will send a Property Tax Statement form for the long term care facility to complete and return with a copy of the tax bill. This will provide information necessary to calculate the real estate tax portion of the capital rate.

2) Beginning with rates to be effective on July 1, 1995, the real estate tax cost described in this Section will be adjusted as follows prior to rate calculation:

A) Any direct appeal cost from Section 140.535(c)(2) will be added. If the same cost reporting period is used to set rates for more than one rate year this cost will only be used for one rate year.

B) If a facility receives a refund of real estate taxes used to calculate a payment rate for the current or previous rate years, a portion of that refund will be offset against real estate tax cost to be used to calculate rates for the next rate year. The full amount of the direct appeal cost reported as a real estate tax cost plus one-half of the amount by which the refund exceeds the appeal cost, will be the offset. For example, assume that a facility receives a refund of

$70,000 in 1994 for taxes paid for 1991, and the facility pays $10,000 in legal fees related to the appeal. The $10,000 legal fee can be reported as a real estate tax cost on the 1994 cost report. Forty thousand dollars of the refund must be offset against the cost that would otherwise be used to calculate the next year's real estate tax rates. The $40,000 is the $10,000 fee plus one-half of the $60,000 excess above the fee. If the same cost reporting period is used to set rates for more than one rate year, this refund will only be offset in one rate year.

C) This benefit of the offset of less than the full refund is only provided to facilities which report that amount of refund on the cost report in the year in which the refund was received or accrued as a receivable. Any unreported refunds will be offset in full and the reported appeal cost will be reclassified as an administrative cost rather than a real estate tax cost.

(Source: Amended at 20 Ill. Reg. 14845, effective October 31, 1996

Section 140.579 Specialized Living Centers

Specialized Living Centers (SLC's) shall divide their reimbursement for capital expenses with the State. The facility shall be reimbursed for actual capital expenses up to a maximum of $3.50 per day for services provided on or after October 1, 1991. The balance of the capital reimbursement shall be retained by the State. In addition, for SLC's incurring necessary major capital improvements due to correction of original construction deficiencies or necessary major construction improvements mandated by the Department of Public Health the expenses of such improvements will be paid up to a maximum of $2.00 per day.

(Source: Expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992)

Section 140.580 Mandated Capital Improvements (Repealed)

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.581 Qualifying as Mandated Capital Improvement (Repealed)

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.582 Cost Adjustments

a) Cost adjustments will be made on a minimum occupancy standard. Facilities having utilization levels below the standard will have their per patient day cost adjusted as if occupancy were at the standard.

1) For capital costs, a standard of 93 percent occupancy or actual, whichever is larger, shall be used.

2) For operating costs (support and nursing), a standard of actual or one3third of the difference between the actual occupancy and 93 percent, if the occupancy rate is below 93 percent, shall be used.

3) The number of licensed beds in the cost reporting year shall be used in the calculation of the minimum occupancy standard.

b) On-site audits and desk audits shall be made to verify the accuracy and reasonableness of reported costs. Adjustments will be made for costs which are not allowable under the Department's rules or are not adequately supported by the facility's records. The Department will notify the nursing home regarding any adjustments made to the cost report as a result of a desk audit. Any objections to these adjustments must be summarized in a letter with all appropriate documentation enclosed to support the requested revision. All documentation and workpapers must be presented in an orderly and organized manner to allow for efficient review. The letter explaining the objections and all supporting documentation must be received by the Department within 45 days of the date of the letter notifying the nursing home regarding cost report adjustments. In order to provide for the efficient and accurate processing of the cost data and payment rates, no further revisions will be made to the desk audit adjustments at the request of the facility or its representatives for information submitted after this 45 day period.

c) Any non-exempt income or contributions available to or received by the recipient or the facility from any source on behalf of the recipient must be deducted in determining the amount of payment authorized by the Department.

(Source: Amended at 12 Ill. Reg. 19396, effective November 6, 1988)

140.583 Campus Facilities

a) A "campus facility" is defined as an entity which consists of a long term care facility (or group of facilities if the facilities are on the same continguous parcel of real estate) which meets all of the following criteria as of May 1, 1987:

1) The entity provides care for both children and adults.

2) Residents of the entity reside in three or more separate buildings with congregate and small group living arrangements on a single campus.

3) The entity provides three or more separate licensed levels of care on the same campus. One of these licensed levels of care must be ICF/MR and the entity must receive funding from the Department of Mental Health and Developmental Disabilities. The facility must also be licensed as a child care institution by the Department of Children and Family Services (see 89 Ill. Adm. Code 404).

b) Allowable costs will be determined under the same guidelines as used for other types of facilities providing services for ICF/MR residents (see Sections 140.530 through 140.541).

c) The campus facility reimbursement rate will be determined using the following steps:

1) Determine the total allowable cost for all residential campus services. Costs for day training, education, and day care services shall not be included in the calculation of the campus facility rate.

2) Obtain the per diem cost by dividing the total allowable cost by the adjusted patient days. The adjusted patient days will be determined in accordance with Section 140.582.

3) The operating costs are adjusted for inflation. The inflation factors will be determined in accordance with the provisions of Section 140.550. The inflated per diem operating costs are added to the per diem capital costs to obtain the updated total per diem cost.

4) The updated total per diem cost is compared to the ceiling. Beginning July 1, 1991, the prior year rate will be multiplied by .15 and added to the lower of the above two amounts to result in the prospective payment rate.

5) The ceiling will be determined at 115% of the average rate being paid to the Specialized Living Centers for ICF/MR residents.

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992; emergency amendments effective September 2, 1993; emergency amendments suspended by action of the Joint Committee on Administrative Rules effective October 12, 1993; emergency amendments repealed at 17 Ill. Reg. 22583, effective December 20, 1993)

Section 140.584 Illinois Municipal Retirement Fund (IMRF)

This Section applies to long term care facilities which are owned and operated by county or municipal governments and which make payments into the Illinois Municipal Retirement Fund (IMRF).

a) For purposes of this Section, a facility shall be deemed to have paid into the IMRF any and all sums paid into said fund on account of persons employed in the facility, regardless of whether or not such payments were made out of funds specifically designated by the county or municipal government for the facility, other specific funds, county or municipal general funds, or any other funds controlled or expended by the county or municipal governing body.

b) The cost report for the county or municipal facility must separately identify IMRF costs in the section of the cost report which requests details regarding employee benefits and payroll taxes.

c) No facility receiving reimbursement for IMRF costs under this Section shall receive reimbursement for the same costs under Section 140.533(g).

d) The IMRF addition to the support rate will be calculated as follows:

1) The total IMRF costs will be divided by adjusted patient days to obtain IMRF per diem cost. The adjusted patient days will be determined in accordance with Section 140.582.

2) The IMRF per diem cost is adjusted for inflation. The inflation factors will be determined in accordance with the provisions of Section 140.550.

3) The inflated IMRF per diem cost from subsection (d)(2) will be added to the support rate determined in accordance with Section 140.561.

(Source: Added at 12 Ill. Reg. 19396, effective November 6, 1988)

Section 140.590 Audit and Record Requirements

a) All audits shall be conducted according to audit principles set forth in the Department's audit guidelines.

b) Maintenance of records

1) All accounting, financial, medical and other relevant records of the provider and related organizations shall be kept for a minimum of 3 years following the date of the filing of the cost report. This must include a copy of the general ledger trial balance indicating how ledger entries were allocated to specific schedules and lines. Records relating to all fixed asset transactions must be maintained for a minimum of three years following the year in which the assets are last recorded in the cost report.

2) The records must be kept in good order in an auditable form.

3) All provider and related organization records shall be made available to the State auditors or their designees and furnished on their request at a single location. If a facility is selected for field audit and some records are maintained at a location outside the State of Illinois, it is the responsibility of the facility to pay for the expense of transporting the records to one location in Illinois or to pay for the expense of transporting the audit team to the out-of-state location. This would include the expense of lodging and meals.

c) Failure of the provider or related organization to furnish needed records or answer essential inquiries shall result in the suspension or termination of Public Aid payments. The suspension of payments shall take effect after written notice to the provider and continue until such time as full cooperation is received.

d) Final audit results will be communicated to the facility within 90 days of the completion of the field audit.

e) In the event that costs are determined to be overstated, the facility shall be liable for a penalty of 5 percent of the overstatement. The Department may also recover any payments, or portions of payments, made to the facility as a result of incorrect statements.

(Source: Amended at 12 Ill. Reg. 19396, effective November 6, 1988)

Section 140.642 Screening Assessment for Nursing Facility and Alternative Residential Settings and Services

a) Beginning July l, l996, any individual, except those identified in subsection (c) of this Section, seeking admission to a nursing facility licensed under the Nursing Home Care Act [210 ILCS 45] for nursing facility services must be screened to determine his or her need for those services pursuant to this Section. Any individual, except those identified in subsection (c) of this Section, who is seeking admission to a nursing facility that operates under the Hospital Licensing Act [210 ILCS 85] must be screened to determine his or her need for those services except when Medicaid funds will not be used for nursing facility services for any part of the stay. For the purposes of this Section, "nursing facility" or “facility” means a location licensed under the Nursing Home Care Act or the Hospital Licensing Act as a skilled nursing facility or an intermediate care facility.

b) Screening Assessment

l) The Level I ID Screen is the first phase of the preadmission screening process for nursing facility services described in subsection (a) of this Section. The Level I ID Screen is conducted to determine if there is a reasonable basis for suspecting that an individual has developmental disabilities (DD), as defined in subsection (b)(1)(A) of this Section, or severe mental illness (MI), as defined in subsection (b)(1)(B) of this Section. This determination is required to assure that individuals with DD or severe MI are placed into settings which provide the services they require. Entities authorized to complete the Level I ID Screen are agents of DPA, Department of Human Services (DHS), Department on Aging (DoA), Department of Public Health (DPH), hospitals or nursing facilities.

A) A developmental disability is a disability that is attributable to a diagnosis of mental retardation (mild, moderate, severe, profound) or a related condition. A related condition is attributable to: cerebral palsy or epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for persons with mental retardation. In addition, this condition is manifested before the age of 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activity:

i) self-care;

ii) understanding and use of language;

iii) learning;

iv) mobility;

v) self-direction;

vi) capacity for independent living.

B) An individual is considered to have a severe mental illness for the purpose of this Section if he or she has one of the following diagnoses: schizophrenia; delusional disorder; schizoaffective disorder; psychotic disorder not otherwise specified; bipolar disorder I - mixed, manic, and depressed; bipolar disorder II; cyclothymic disorder; bipolar disorder not otherwise specified; major depression, recurrent; and due to his or her mental illness exhibits resulting substantial functional limitations. The functional limitation must be of an extended duration expected to be present for at least a year, which results in substantial limitation in major life activities affecting at least two of the following areas:

i) self-maintenance;

ii) social functioning;

iii) community living activities;

iv) work related skills.

2) If the Level I ID Screen indicates that an individual may have DD or severe MI, a comprehensive assessment, the Level II assessment, except as defined in subsection (b)(7) of this Section, is conducted by preadmission screening (PAS) agents designated by the DHS-Office of Developmental Disabilities or DHS-Office of Mental Health, whichever is applicable, concerning the need for nursing facility services and the need for specialized services.

3) If the Level I ID Screen does not identify a reasonable basis for suspecting

DD or severe MI, the individual is referred to DoA (individuals 60 years of age or older) or DHS-Office of Rehabilitation Services (individuals l8 through 59 years of age) for a Determination of Need to assess the need for nursing facility services.

4) For applicants of Medicaid services who are already residing in the facility and were admitted after June 30, 1996, the Department will review and evaluate a copy of the most recent Minimum Data Set (MDS) resident assessment instrument. The Department will refer to DoA or DHS, as appropriate, any light need resident who appears to be a potential candidate for community placement.

5) A screening assessment is valid for 90 calendar days from the date of the assessment. For individuals with DD or severe MI, an existing Level II assessment may remain valid after 90 calendar days when the designated PAS agent updates any component of the assessment which is not current, and confirms the validity of the assessment as reliably reflecting the status of the individual.

6) Due to exceptional circumstances, an individual identified as having DD or MI, following a Level I ID Screen, may be determined to need nursing facility services. The individual with exceptional circumstances must then receive a Level II assessment to determine the individual's need for specialized services related to placement in a nursing facility, except in the specific circumstances noted in subsection (b)(7) of this Section. Exceptional circumstances include, but are not limited to:

A) terminal illness with a life expectancy of six months or less; and

B) convalescent care (a medically prescribed period of recovery, following acute care, not to exceed 120 calendar days); and

C) severe physical illnesses, such as coma, ventilator dependence, functioning at brain stem level or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure; and

D) a diagnosis of dementia, including Alzheimer's disease or a related disorder, in the case of the individual with DD.

7) Level II assessment exemption. Some individuals with DD or severe MI

may be admitted to a nursing facility without receiving a Level II assessment to determine the need for specialized services by a designated PAS agent. Individuals exempt from a Level II assessment for specialized services are provisional admissions pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears. In all other cases, a determination that specialized services are not needed must be based on a Level II assessment.

8) Screening agents shall present alternatives to institutional placement, and inform individuals of alternative settings before placement into a nursing facility.

9) Non-Medicaid supported individuals who choose to be admitted into a nursing facility when the screening assessment does not justify nursing facility placement will not be denied access to the facility.

c) A screening assessment does not apply to an individual who:

1) is receiving or will be receiving sheltered care services; or

2) transfers from one facility to another, with or without an intervening hospital stay. It is the transferring facility's responsibility to ensure that copies of the resident's most recent screening assessment accompany the transferring resident; or

3) resided in a facility for a period of at least 60 days and is returning to a facility after an absence of not more than 60 days; or

4) is receiving or will be receiving hospice services; or

5) is readmitted to a facility after a therapeutic home visit; or

6) is readmitted to a facility from a hospital to which he or she was transferred for the purpose of receiving care; or

7) resided in the facility on June 30, l996.

d) Nursing Facility Services

In Illinois, nursing facilities are licensed for intermediate level nursing care and skilled level nursing care. For guidelines to the type of services provided by nursing facilities refer to 77 Ill. Adm. Code 300.Appendix A.

e) Date of Payment

1) No payment for nursing facility services may be made for individuals who: have been determined eligible, or have applied for Medicaid at the point of admission, unless the screening assessment documents a need for such care.

2) Where the assessment does not establish this need, the individual may request that a licensed physician designated by DPA review the medical reports and any other evidence the individual wishes to submit, and certify whether there is a need for nursing facility services in the individual's case. The individual will be notified of the right to this review.

3) For an individual whose preadmission screening assessment has been completed prior to admission, DPA will begin payment:

A) on the date of admission if Medicaid eligibility has been established, or

B) on the beginning date of Medicaid eligibility if eligibility starts after the date of admission.

4) For an individual whose preadmission screening assessment has not been completed prior to admission, DPA will begin payment on the later of:

A) the date that the screening assessment requirement is met, or

B) the effective date of Medicaid eligibility.

5) For an individual who applies for Medicaid after admission to a facility, DPA will begin payment on the effective date of Medicaid eligibility.

f) Review Required Upon Change in DD/MI Resident Condition
Nursing facilities must notify the State mental health authority or the State developmental disability authority, or their designee as applicable, when there has been a significant change in the condition of a Medicaid eligible resident with developmental disability or severe mental illness as required by 42 USC 396r(e)(7)(B)(iii)(1999). The nursing facility shall report in a format established by the applicable State authority, or its designee, significant changes in a resident's condition. A determination will then be made whether there has been a significant change requiring a resident review. For the purposes of this subsection (f), a significant change for a resident with severe mental illness or

developmental disability will be deemed to have occurred when:

1) An individual who was determined by PAS to be severely mentally ill, and who has continuously resided in a nursing facility within the last 12 months, who has been referred for admission or been admitted to a psychiatric hospital or psychiatric ward of a general hospital for psychiatric care three or more times within that 12 month period; or

2) An individual who was determined by PAS to be severely mentally ill or developmentally disabled is evaluated by the nursing facility to no longer have a severe mental illness or developmental disability; or

3) An individual who was determined by PAS not to be severely mentally ill or developmentally disabled is evaluated by the nursing facility to have a severe mental illness or developmental disability. There must be a reasonable basis for believing that the condition may indicate the presence of a developmental disability prior to the age of 22; or

4) An individual who was determined by PAS to be severely mentally ill who does not have a medical need for nursing facility level of care, meets all of the following:

   A) no longer receives any intervention programs for mood, behavior or cognitive loss;

   B) has successfully completed training skills required to return to the community; and

   C) discharge to the community is not planned within the next 90 days; or

5) An individual who was determined by PAS to be developmentally disabled no longer receives specialized services; or

6) An individual with severe mental illness or an individual with a developmental disability who entered the nursing facility as an exempted hospital discharge is now found to require more than 30 days of nursing facility care.

g) Periodic Resident Review
The Department, the Department of Public Health, or their agents may periodically review some or all Medicaid eligible residents found to be severely

mentally ill or developmentally disabled to evaluate nursing facilities' compliance with this Section.

(Source: Amended at 27 Ill. Reg.14799, effective September 5, 2003)

Section 140.643 In-Home Care Program

The State of Illinois shall operate an In-Home Care Program designed to promote proper utilization of long term care services and prevent unnecessary institutionalization. The programs will be operated by the Departments on Aging (clients 60 and older), Rehabilitation Services (physically disabled) and Mental Health and Developmental Disabilities (developmentally disabled). The Department of Public Aid, as the single state agency under Medicaid, is responsible for claiming Federal Financial Participation and is the State of Illinois' contact with the Federal government in relation to the In-Home Care Program. Specific eligibility criteria and all other relevant factors of the In-Home Care Program are contained in the Rules of the operating agencies – the Department on Aging (89 Ill. Adm. Code Section 04-60.000 et seq.), the Department of Rehabilitation Services (89 Ill. Adm. Code, Chapter IV, Subchapter d) and the Department of Mental Health and Developmental Disabilities (proposed 59 Ill. Adm. Code 120).

(Source: Amended at 18 Ill. Reg. 5951, effective April 1, 1994)

Section 140.645 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21 (Repealed)

(Source: Repealed at 28 Ill. Reg. 13775, effective October 1, 2004)

Section 140.646 Reimbursement for Developmental Training (DT) Services for Individuals With Developmental Disabilities Who Reside in Long Term Care (ICF and SNF) and Residential (ICF/MR) Facilities

a) Residential providers are responsible for ensuring the provision of a continuous program of active treatment services for each resident (42 CFR 483.410(d) and 42 CFR 483.440). The Department (DPA) will reimburse SNF, ICF and ICF/MR facilities (including ICF/MR-15, Specialized Living Centers (SLC), and ICF/MR-SNF/PED) through a separate component of the per diem for DT services provided to residents who have developmental disabilities. Such individuals would be identified as needing DT by the facility's interdisciplinary team. The facilities may contract for these services from community providers whose programs are certified by the Department of Mental Health and Developmental Disabilities (DMHDD), or may provide their own DT if the DT Program is certified by the Department of Mental Health and Developmental Disabilities (DMHDD), and conducted by staff of the DT program. The DT program is defined as the distinct part of a long term care or residential facility, or an independent business entity certified by DMHDD to provide DT services.

b) Billing by the facility and payment by the Department for each month of active treatment services provided by the facility includes DT services.

c) Timely Billing Flow-Through for DT Services

1) Claims for reimbursement for DT services must be received by the Department no later than the close of business on the 16th day of the month following the previous month of DT services. If the 16th day of the month falls on a weekend, billing must be received by the Department no later than the close of business of the Friday before that weekend.

2) If the billing for DT services is not received by the Department as specified in subsection (c)(1) above, a hold will be placed on the processing of the facility's claims for reimbursement and subsequent payment for services. The hold on processing of facility billing and payment for services will be lifted once the DT billing has been received.

3) The turnaround of DT attendance records from the DT provider to the facility must also be timely. These records are utilized by the facility to complete billings forms for DT services. DT attendance records should be received by the facility by the 7th day of the month following the previous month of DT services. The facility must notify the Department five (5) working days before the 16th day of the month if the attendance records

regarding DT services have not been returned to the facility. When DT billing is late due to a delay by the DT agency in submitting attendance records, no hold will be placed on facility billings or payments.

d) Timely Payment Flow-Through for DT Services

1) The facility must flow-through payments to the DT agency for DT services no later than ten (10) working days after facility receipt of the payment from the Department, unless the facility itself operates the DT program. The expected time frame for the DT agency to receive its flow-through payment is twenty (20) calendar days (5 days in the mail from the Department to the facility, no more than 10 days to issue payment, and 5 days in the mail from the facility to the DT agency). Facilities may incur penalties under Sections 140.16 and 140.17 for violations of this requirement.

2) When the Department is notified that reimbursement for DT services has not been received by the DT agency within the specified time frame, Department staff will contact the residential provider and request a copy of the cancelled check which was issued for DT services. If the facility is unable to demonstrate to the Department that the DT payment has been received by the DT agency, the Department will take the actions provided in subsection (d)(3) below.

3) If the DT payment has not been received by the DT agency within twenty (20) calendar days following Department release of the payment to the facility, a hold will be placed on the processing of facility billing and payment for facility services. The hold on facility billing and payment will be lifted when the DT agency has received the outstanding payment for services.

e) Change of Ownership/Operator

1) Billing and payment for DT services must be processed and either paid in full or incurred as a debt whenever there is a change in ownership or licensed operator of a Medicaid funded residential facility. The transaction to change a licensed operator or transfer ownership must include a recognition of all debts of unprocessed and/or unpaid billings.

2) The Department will not enter into a provider agreement with a residential provider unless:

A) payment is made in full for all DT services by the previous owner/operator; or

B) the amount is incurred as a debt to be paid in full by the new owner/operator within forty-five (45) calendar days after becoming the new owner/operator when the Department has paid the facility in full prior to the change in ownership or licensed operator for all DT services provided under the previous owner; or

C) the amount is incurred as a debt to be paid in full by the new owner/operator within ten (10) working days after facility receipt of the payment from the Department, when such payment reaches the facility on or after the effective date of the change in ownership or licensed operator.

3) If the new owner/operator does not pay the full amount due the DT agency by the end of the forty-five (45) day period as specified in subsection (e)(2)(B) above, or by the end of the ten (10) day period as specified in subsection (e)(2)(C) above, a hold on the reimbursements will be implemented. The hold on facility billings and payment will be lifted after the DT agency has been paid in full for the indebted amount.

f) Providers of DT programs services will be responsible for providing any required transportation between the program and the facility. Reimbursement for transportation costs is included in the DT program monthly rate as established in Section 140.648. The DT Program contracting with a long term or residential facility may not elect to discontinue the provision of transportation.

g) The term Mentally Retarded and related conditions, as used in rules contained in Sections 140.646 – 140.652 refers to individuals meeting the definition of mental retardation or related conditions as described in 42 CFR 435.1009 (1989).

h) The term "facility" which is used in rules contained in Sections 140.646 – 140.652 is understood to refer to long term care facilities (ICF and SNF,) and residential facilities (ICF/MR, including ICF/MR-15, SLC, and ICF/MR-SNF/PED).

i) Persons with developmental disabilities who are residents of facilities, and whose public school special education services have been terminated, are deemed eligible for DT services.

j) DT programs shall be subject to review as part of the Department's evaluation of recipient care under its utilization and medical reviews of long term care and

residential facilities (Section 140.512).

k) Payment may be approved for DT services, during a DT participant's hospitalization, for a period not to exceed 10 days. Such payments:

1) are limited to individuals who will be returning to the same facility,

2) are a daily rate at 75% of the individual's current DT per diem rate.

(Source: Amended at 16 Ill. Reg. 1877, effective January 24, 1992)

Section 140.647 Description of Developmental Training (DT) Services

Developmental training (DT) provides services to individuals with developmental disabilities and major functional skill deficits in one or more developmental areas with the goal of helping such individuals achieve functional independence.

a) General Specifications

1) Developmental training refers to specific programs, interventions, therapies and activities. DT is usually conducted in nonresidential settings, but shall be conducted in residential settings for individuals having physical/medical impairments so severe that nonresidential participation is prohibited. A DT program conducted in a residential setting shall be conducted by staff of the DT program, and be certified by the Department of Mental Health and Developmental Disabilities (DMHDD) (Section 140.646(a). Developmental training services provide continuity and integration of the Individual Program Plan (IPP) as required for a continuous active treatment program for each individual (42 CFR 483.440 (1989) and 89 Ill. Adm. Code 144.25 and 144.105). DT shall also include services designed to improve an individual's ability to engage in productive work activities, whose impairment is so severe as to make the individual's production capacity inconsequential as defined in 29 CFR 525.2(c) (1984).

b) Eligibility

1) A minimum level of skill development shall not be required for entry into DT.

2) Eligibility criteria for DT services are:

A) The individual shall reside in a residential facility (ICF/MR) or a LTC facility (SNF or ICF); and

B) The individual's need for active treatment services shall be identified as described in Section 140.642 (g) and Section 140.Table H.

c) Documentation Reports

1) Determination of the appropriateness of DT shall be the responsibility of the facility's interdisciplinary team (IDT). The IDT shall include the

individual being served, unless clearly unable to participate; the individual's family, unless unable or unwilling to participate; the individual's legal guardian, if applicable; representatives from the various disciplines participating or proposed to participate in the provision of services to the person; and a representative from the entity or entities responsible for service delivery, including at least one representative each from the facility and DT Program. At least one member of the IDT shall be a Qualified Mental Retardation Professional (QMRP) (as defined in 42 CFR 483.430 (1989).

2) These services shall be provided under a written plan of care developed in accordance with 42 CFR 483.440 (1989). The plan of care shall be the one developed by the facility's IDT, and shall identify the responsibilities of the facility and DT program in executing the plan. Services provided by the facility and the DT program under the plan of care shall demonstrate an integrated and consistent approach to the goals identified by the IDT. Agreement about the IPP, assessed level of functioning, specialized service needs, and specialized equipment must be demonstrated by all IDT members, including but not limited to, representatives from the facility, the DT program, and the individual or his/her guardian.

3) No services shall be provided which are solely related to preparing the client for paid or unpaid employment, or with the reasonable expectation that the client would be able to currently participate in a sheltered workshop or enter the general work force within one year.

4) An individual shall engage in prevocational or work-related skills training. These activities shall directly address the service needs identified in the plan of care, and may not be provided for the primary purpose of earning wages or increasing production rate. Such training activities must be integrated with the overall IPP and meet active treatment requirements. All activities performed as part of a production process or contract work fall within this definition.

5) Decisions about placement into DT shall be based upon a systematic assessment of the individual's developmental level in the areas identified. The assessment shall be conducted by or under the supervision of the IDT (as defined in Section 140.647(c)). A reassessment of the individual's developmental levels and a redetermination of the appropriateness of the individual's current placement shall occur at least annually. Documentation of the individual's developmental level shall allow

independent verification of the appropriateness of the placement decision by using a generally accepted assessment instrument as described in Section 140.648(c)(1)(A)(i) and (ii) and 89 Ill. Adm. Code 144.75 (a)(2)(B).

6) The requirements of this section shall not prevent an individual from participating in DT solely due to a disability which negates any possibility of improvement in one or more developmental areas. An individual's inability to achieve improvement in a particular developmental area due to a disability must be established through documentation by the IDT of the failure of an intensive program to produce improvement in that area over a period of one year or more, as determined by the IDT. This documentation requirement shall be waived when the disability such as blindness, obviously prevents improvement in a specific task related area.

7) Other exceptions to these placement criteria may be made only if a documented justification for such an exception is approved by the IDT (as defined in subsection (c)) and the Department.

(Source: Amended at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.648 Determination of the Amount of Reimbursement for Developmental Training (DT) Programs

a) A DT program which is certified by the Department of Mental Health and Developmental Disabilities (DMHDD) shall be reimbursed for active treatment services delivered on or after January 1, 1990, to eligible participants.

b) The total rate shall be comprised of a Program Component and an Agency Component. Reimbursement levels for the Program Component shall be derived from four determinants which, in combination, shall result in the total Program per diem amount. The four determinants will be reviewed and validated according to information provided in the most recent Inspection of Care (IOC) conducted by Department surveillance staff in a long term care (LTC) facility (nursing facility or ICF/MR). Where dollar, wage or salary amounts are used, respective amounts shall be inflated to the fiscal year for which reimbursement shall be made.

c) Program Component. The four determinants which result in the total Program Component per diem are:

1) Direct Services –DT agencies shall be in compliance with the Health Care Financing Administration's (HCFA) minimum average daily staffing standards (42 CFR 442.430 (1990)) relative to client population according to each individual's overall level of functioning. In order to meet and exceed the staffing standards set by HCFA and to assure adequate reimbursement for the delivery of active treatment services, the Department shall base reimbursement for direct service staff at the following per shift ratios:

Overall Level of Functioning	FTE* Staff:Client Ratio
Mild	1:10
Moderate	1:8
Severe-Profound	1.5

*FTE = Fu;; Time Equivalent

A) Determination of levels of functioning of clients with mental retardation and related conditions, in accordance with the definition of the American Association of Mental Retardation (mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental

period), shall include both:

i) an assessment of intellectual functioning as measured by a standardized, full scale, individual intelligence test such as the Stanford Binet and WAIS-R. Such an assessment shall be administered by a psychologist who is registered in Illinois under the Illinois Psychological Act (Illinois Department of Professional Regulation); and

ii) an assessment of adaptive behaviors using a nationally standardized, Department approved assessment instrument, such as the Scales of Independent Behavior (SIB), or the Inventory For Client and Agency Planning (ICAP). Such an assessment instrument shall be utilized by at least one Qualified Mental Retardation Professional (QMRP) (89 Ill. Adm. Code 144.275 (b)(1) and 42 CFR 483.430 (1989)) to evaluate each client's functional skills and adaptive behaviors. The Scales of Independent Behavior and the Inventory for Client and Agency Planning are published by, and available from, DLM Teaching Resources, 1 DLM Park, Allen, Texas 75002 (1-800-527-4747). The 1986 edition is incorporated and no later amendments or editions are included.

iii) The final determination of each client's overall level of functioning employs both the assessment of intellectual functioning and the assessment of adaptive behaviors, and will be made according to the criteria set forth in 89 Ill. Adm. Code 144.Table D and 144.Table E.

B) Reimbursement for direct services is calculated by: determining the number of clients within each level of mental retardation; dividing each number by the client component of the staff: client ratio; summing these quotients; multiplying the sum by the aide hourly wage factor and then by 2080 (52 weeks times 40 hours per week); then multiply by 1.08 (vacation and sick time factor) to obtain a total annual direct service cost; and dividing this total by the annual client days to obtain the amount for direct services per client per day. For the calculation method and an example, see 89 Ill. Adm. Code 144.275(a)(1)(C)(i).

2) Qualified Mental Retardation Professional – The supervisor of active

treatment services in the developmental training environmental is the QMRP. To determine the reimbursement amount for QMRP supervisory staff, assume that a full-time QMRP is required for every 30 individuals who are certified for ICF/MR services. Reimbursement for QMRP services is calculated as follows: the number of QMRPs shall be obtained by dividing the number of clients in the DT program by 30; the obtained number of QMRPs is multiplied by the hourly wage factor and then by 2080 (52 weeks times 40 hours per week); and then multiply by 1.08 (vacation and sick time factor); the product is divided by the annual client days.

3) Specialized Care – An amount shall be paid for clients who are in need of Specialized Care for Behavior Development Programs and/or Health and Sensory Disabilities. Complete descriptions of Specialized Care are found in 89 Ill. Adm. Code 144.125 and 144.150. Identification and validation of an individual's need for either or both categories of Specialized Care will be made during the annual IOC of the LTC facility where the individual resides.

A) In each category of Specialized Care, there are three levels of services. The service level for each client meeting the criteria of more than one service level in a category of Specialized Care shall be determined according to the one level which shall result in the greatest reimbursement amount. Reimbursement for the three levels is determined on the basis of:

i) Level 1 – .50 hours of Direct Service per service day.

ii) Level II – 1.0 hours of Direct Service per service day.

iii) Level III – 2.0 hours of Direct Service per service day. Reimbursement for clients who qualify for Level III in the category of Health and Sensory Disabilities is also made for 3.0 hours of licensed nurse time, at a ratio of 1:30 per service day.

B) The reimbursement amount for Specialized Care is determined according to the calculation method in subsection (c)(1)(B) above.

4) Related Program Costs – These costs include program materials, equipment, consultants and similar items necessary for the individual's DT program. The amount paid per client per day is determined as follows:

Add the amounts calculated for Direct Services, QMRP and Specialized Care, and multiply this sum by the Developmental Training Regional Adjuster. The Regional Adjuster for DT programs in Health Service Areas (HSA) 6, 7 and 8 is 1.2; for all other HSAs, the Regional Adjuster is 1.0. The product is then multiplied by .10.

5) Total Program Component Per Diem – The total Program Component rate shall be the sum of the amounts for the four determinants (see subsection (c)(1), (2), (3) and (4) above).

d) Agency Component. The Agency Component per diem will be a flat rate for costs of capital, support and transportation. Transportation is the conveyance of clients from the LTC facility to the DT site, and is the responsibility of the provider of the DT program services. For clients who have special transportation needs, such as vehicles modified for wheel chairs and positioning equipment, an upward adjustment shall be made to the Agency Component per diem. Clients who require special transportation are identified according to their Specialized Care service levels, which are verified during the IOCs of their residences (LTC facilities).

e) Total Per Diem Rate

1) The total per diem for each client is the sum of the Program Component, subsection (c)(5) above and the Agency Component, subsection (d) above.

2) The per diem rate for a DT program, based on IOC information, is the mean of per diems for eligible and enrolled clients.

f) The DT program may appeal for redetermination of the monthly rate established by the Department within 30 days after receiving notification of the rate by submitting an application to the IDPA. If a LTC facility initiates such an appeal without the concurrence of the affected DT program, the appeal will not be honored. The application must identify the basis for the appeal and provide all necessary documentation to explain and justify the basis.

g) The Department shall make an advance payment for DT services to a LTC facility that contracts for such services with a certified DT program. The amount of the advance payment shall be equal to the unadjusted reimbursement the facility would receive for two months of service for the number of clients enrolled in DT. The LTC facility shall use this advance payment to provide advance payment to the DT program serving its residents in accordance with Section 140.646(b). Facilities eligible to receive an advance payment must contract with a certified

DT program which meets one of the following criteria:

1) The DT agency is a newly certified program, or

2) The DT agency experiences a significant increase in enrollment which results in:

   A) a 20% client enrollment within one month, or

   B) increased costs due to the need for a new setting.

3) The LTC facility shall submit a written request for a two-month advance payment to the Bureau of Disability Services. The letter shall state the reason for the advance, the clients involved (include the Public Aid ID numbers), and the DT rate of each client. The Department shall begin recovering the payment three months after the advance is issued. The recoupment shall be made in six equal installments via credit applied to the following six months of service. In the event that the facility terminates its contract for DT services before the last month of recoupment, the Department shall recover the entire amount of the advance payment in the month of contract termination, from facility claims processed by the Department. If the amount of such claims is insufficient for recovery of the advance payment balance due, or if such claims have been processed by the Department's payment system prior to contract termination, the advance payment balance shall become immediately due upon contract termination, payable by check to the Illinois Department of Public Aid.

(Source: Amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendments effective September 2, 1993; emergency amendments suspended by action of the Joint Committee on Administrative Rules effective October 12, 1993; emergency amendments repealed at 17 Ill. Reg. 22583, effective December 20, 1993)

Section 140.649 Effective Dates of Reimbursement for Developmental Training (DT) Programs

a) The effective date of reimbursement to the facility for DT services will be the later of the dates when the following criteria have been met:

1) receipt by the Department of an addendum to the provider agreement containing the assurances specified in Section 140.652, and

2) receipt by the Department of a completed Enrollment Form, (Form DPA 2768). The Enrollment Form shall specify, in accordance with instructions, the effective date of each recipient's enrollment. The Enrollment Form for each recipient shall be signed by a representative of both the facility and the DT program.

b) In no event shall the Department provide reimbursement for DT services provided by a DT program prior to the effective date of the recipient's enrollment.

c) Rates determined by Section 140.648 shall be based on DT services delivered on or after January 1, 1990.

(Source: Amended at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.650 Certification of Developmental Training (DT) Programs

In order for a facility to qualify for reimbursement of DT services, it must execute a written agreement with a DT program that is certified by the Department of Mental Health and Developmental Disabilities (DMHDD) in accordance with the standards set by that department.

(Source: Amended at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.651 Decertification of Day Programs

a) The Department of Mental Health and Developmental Disabilities (DMHDD) is responsible for decertification of DT Programs. When a DT Program has been decertified by the DMHDD, it may appeal the decertification in accordance with rules of the DMHDD. Facilities having a written agreement with the DT Program shall continue to be reimbursed throughout the appeal process.

b) When the DMHDD decertifies a DT Program, reimbursement to the facility will be reduced by the amount that is applicable to the DT Program effective with the date of decertification.

(Source: Amended at 11 Ill. Reg. 9169, effective April 28, 1987)

Section 140.652 Terms of Assurances and Contracts

A facility requesting reimbursement for developmental training DT services provided by a DMHDD certified DT program must submit to the Department an addendum to its provider agreement (Form DPA 1432) containing an assurance that the facility has a signed agreement with a certified (DT) program. This agreement must specify at a minimum:

a) the duration of the agreement;

b) conditions under which the agreement may be terminated prematurely by either party;

c) the number of hours per day, consistent with DMHDD certification requirements, that (DT) will be provided exclusive of transportation time and meal time;

d) a schedule of the days that (DT) services will be provided;

e) the responsibilities of both parties regarding the joint planning and delivery of services and the sharing of progress notes, and

f) the understandings agreed to by both parties regarding the documentation of attendance.

(Source: Amended at 14 Ill. Reg. 18508, effective October 30, 1990)

Section 140.680 Effective Date of Payment Rate

a) Notwithstanding any other provisions of these rules, there shall be no rate increase for long term care facilities for Calendar Year l983, or the first six months of Calendar Year l984.

b) For Calendar Year l984 and subsequent years, the rate established annually pursuant to the method described in these rules shall be effective on July lst.

(Source: Amended at 7 Ill. Reg. 12868, effective September 20, 1983)

Section 140.700 Discharge of Long Term Care Residents

a) A nursing facility participating in the Medical Assistance Program is prohibited from failing or refusing to retain as a resident any person because he or she is a recipient or an applicant for the Medical Assistance Program. A recipient or applicant shall be considered a resident in the nursing facility during any hospital stay totaling ten days or less following a hospital admission

b) If a nursing facility should refuse to accept a resident back in the facility after a stay in the hospital of less than ten days, the result may be that the resident will thereafter incur hospital bills of a greater amount than the nursing facility care would have cost. If the Department were to become liable to pay such hospital bills as a result of the nursing facility's refusal to take the recipient back into the facility, the Department shall recoup its costs for that unnecessary hospitalization from the nursing facility. The provider will be required to pay the Department the portion of the hospital bill that is in excess of the amount that would otherwise have been paid for care in the nursing facility from the date on which the nursing facility refused to accept the resident's return. The Department will notify the provider of its intent to recoup and opportunity for a hearing shall be given pursuant to 89 Ill. Adm. Code 104, Subpart C.

c) A nursing facility must establish and follow a written policy under which a resident, whose hospitalization exceeds ten days or therapeutic leave exceeds the bed reserve period specified in Section 140.523, is readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private, same sex room if the resident requires the services provided by the nursing facility and is eligible for Medicaid certified facility services.

d) The nursing facility must permit each resident to remain in the nursing facility and not transfer or discharge the resident except in specific instances as stated at 77 Ill. Adm. Code 300.3300(c)(1)(A) through (C).

e) For all Medicaid certified nursing facilities, notice of transfer or discharge must be made to any resident 30 days before the resident is transferred or discharged as mandated by 42 CFR 483.12 (a)(4)(B). In addition to requirements stated at 77 Ill. Adm. Code 300.3300 (e), the contents of the notice shall also include requirements under 42 CFR 483.12 (a)(5).

f) Pursuant to Section 1919(c)(2)(F) of the Social Security Act and Section 140.506, a nursing facility that voluntarily withdraws from participation in the Medical Assistance Program, but continues to provide nursing facility services, is prohibited from using the facility’s voluntary withdrawal from participation as an

acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal, including those residents who were not entitled to coverage under the Medical Assistance Program as of that day.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.830 Appeals of Rate Determinations

a) Except as indicated in subsection (b) of this Section, the Department shall notify all nursing facilities of their support and capital rates for the next year no later than 30 days before the beginning of the rate year, which shall be the same as the State's fiscal year. Appeals of rate determinations shall be submitted in writing to the Department. Except as indicated in subsection (b) of this Section, appeals received within 30 days after rate notification shall, if upheld, be made effective as of the beginning of the rate year. The effective date of all other upheld appeals shall be the first day of the month after the date the complete appeal was received.

b) The Department shall notify all nursing facilities of their nursing rate no later than 30 days before the beginning of the rate quarter pursuant to 89 Ill. Adm. Code 147.150. Appeals shall be submitted to the Department no later than 30 days after the date of the Department's notice to the facility of the rate. The results of an appeal shall become effective the first day of the applicable quarter.

c) Appeals of rate determinations under this Section shall be submitted in writing to the Chief, Bureau of Long Term Care. The Department shall rule on all appeals within l20 days after the date of appeal, except that if the Department requires additional information from the facility the period shall be extended until such time as the information is provided. Except for the rate identified in subsection (b) of this Section, appeals for any rate year must be filed before the close of the rate year.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.835 Determination of Cap on Payments for Long Term Care (Repealed)

(Source: Repealed at 16 Ill. Reg. 6408, effective March 20, 1992)

SUBPART F: FEDERAL CLAIMING FOR STATE AND LOCAL GOVERNMENTAL ENTITIES

Section 140.850 Reimbursement of Administrative Expenditures

The Department may seek federal reimbursement for expenditures incurred by other State agencies and local government entities that are in support of any medical assistance program or programs administered by the Department if that agency or entity meets all of the following requirements:

a) Executed Agreement
The Department will only accept, process and submit a claim for federal reimbursement if the claiming State agency has on file with the Department an executed interagency agreement relating to the subject matter for which the claiming State agency is seeking federal reimbursement. A non-State government claiming entity must have an executed intergovernmental agreement on file with the Department in order for the Department to accept, process and submit a claim for federal reimbursement relating to the subject matter for which the claiming non-State government agency is seeking federal reimbursement.

b) Cost Allocation Plan
Claims for federal reimbursement of administrative expenditures must be submitted to the Department in accordance with a cost allocation plan that has been approved by the Department and is acceptable to the appropriate federal agency.

(Source: Added at 25 Ill. Reg. 11880, effective September 1, 2001)

Section 140.855 Administrative Claim Review and Reconsideration Procedure

a) The Department may reject all or any portion of a claim for federal reimbursement that is not in compliance with State or federal law, regulation, policy or applicable intergovernmental or interagency agreement. The claiming entity may request an informal review and reconsideration of the Department's decision to reject all or any portion of a claim for federal administrative reimbursement.

b) The Department provides the following review procedure by which the State agency or local government entity may seek an informal review and reconsideration of the Department's decision to reject all or any part of a request for federal administrative reimbursement:

1) The request for review must be submitted in writing to the Department.

2) The request for review must be received by the Department within 30 days after the date of the Department's notice to the claiming entity of a Department adjustment to a claim.

3) A request for review from the claiming entity shall include a clear explanation of the reason for the request and documentation supporting the desired correction.

4) Review shall be limited to technical errors in calculations related to the cost allocation plan.

5) The Department shall notify the claiming entity, in writing, of the results of the review within 30 days after receipt of the claiming entity's request for review.

(Source: Added at 25 Ill. Reg. 11880, effective September 1, 2001)

Section 140.860 County Owned or Operated Nursing Facilities

a) Subject to federal approval, the Department shall draw the eligible amounts of federal monies for the covered expenditures in accordance with Section 140.530(c)(2), intergovernmental agreements between the county and State, and applicable federal regulations.

b) Subject to federal approval, the Department shall authorize payment to the county within 45 days after receipt of the federal monies drawn for the certified expenditures unless the county has not provided complete, accurate and valid expenditure reports with appropriate documentation.

(Source: Added at 34 Ill. Reg. 3761, effective March 14, 2010)

Section 140.865 Sponsor Qualifications (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.870 Sponsor Responsibilities (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.875 Department Responsibilities (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.880 Provider Qualifications (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.885 Provider Responsibilities (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.890 Payment Methodology (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.895 Contract Monitoring (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.896 Reimbursement For Program Costs (Active Treatment) For Clients in Long Term Care Facilities For the Developmentally Disabled (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 146.225 at 13 Ill. Reg. 7040)

Section 140.900 Reimbursement For Nursing Costs For Geriatric Residents In Group Care Facilities (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.5 at 12 Ill. Reg. 6956)

Section 140.901 Functional Areas of Needs (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.25 at 12 Ill. Reg. 6956)

Section 140.902 Service Needs (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.50 at 12 Ill. Reg. 6956)

Section 140.903 Definitions (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.75 at 12 Ill. Reg. 6956)

Section 140.904 Times and Staff Levels (Repealed)

(Source: Repealed at 11 Ill. Reg. 16758, effective September 28, 1987)

Section 140.905 Statewide Rates (Repealed)

(Source: Repealed at 11 Ill. Reg. 16758, effective September 28, 1987)

Section 140.906 Reconsiderations (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.150 at 12 Ill. Reg. 6956)

Section 140.907 Midnight Census Report (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.105 at 12 Ill. Reg. 6956)

Section 140.908 Times and Staff Levels (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.125 at 12 Ill. Reg. 6956)

Section 140.909 Statewide Rates (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.150 at 12 Ill. Reg. 6956)

Section 140.910 Referrals (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.175 at 12 Ill. Reg. 6956)

Section 140.911 Basic Rehabilitation Aide Training Program (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.200 at 12 Ill. Reg. 6956)

Section 140.912 Interim Nursing Rates (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 147.250 at 12 Ill. Reg. 6956)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section 140.920 General Description

a) The Maternal and Child Health Program is a primary health care program coupled with case management services for Medicaid enrolled pregnant women and children. The program is designed to ensure access to quality health care services

b) Case Management Component
The Maternal and Child Health Program shall include a case management component which shall be in place statewide. Under the case management component, pregnant women and infants under the age of 12 months will be provided with case management services, as described in Section 140.922(c), by a community-based case management agency that will be responsible for assisting the client in accessing health care and support services necessary to comply with their physicians' recommendations. Such case management services will be provided through age five years for DCFS wards.

c) The Maternal and Child Health Program is designed to increase provider participation through special incentives for providers for certain services provided to pregnant women and children under age 21. These include increased payment rates for selected services, as described in Section 140.930, and expedited payment. To participate in the program, providers must meet specific participation requirements, as described in Section 140.924, and sign a Maternal and Child Health provider agreement, in addition to being enrolled as a Medicaid Provider. Under the Maternal and Child Health Program the Department agrees to:

1) Pay enhanced rates for prenatal risk assessment, which includes substance abuse information,

2) Pay enhanced rates for delivery services,

3) Pay enhanced rates for primary care office visits and screening services provided to children,

4) Provide prospective payment or expedited processing of claims for physicians who request special processing,

5) Upon request of medical providers, furnish client eligibility and profiles of prior services reimbursed by the Department,

6) Facilitate access to medical care for clients in cooperation with the physician and case management entity.

d) Those clinics which were enrolled under the Healthy Moms/Healthy Kids Program shall be deemed certified in the Maternal and Child Health Program.

e) Those providers enrolled under the Healthy Moms/Healthy Kids Program shall be deemed certified in the Maternal and Child Health Program.

(Source: Amended at 20 Ill. Reg. 4345, effective March 4, 1996)

Section 140.922 Covered Services

a) Medical Services
All services covered under the Illinois Medical Assistance Program shall be available to recipients participating in the Maternal and Child Health Program.

b) Case Management Services
Case management for Medicaid recipients is defined as a function necessary for the proper and efficient operation of the Medicaid State Plan. Services include but are not limited to:

1) Coordination of Medicaid covered services;

2) Arranging for transportation to and from a source of medical care;

3) Client education regarding covered services, the benefits of preventive medical and dental care, and how to efficiently utilize the health care system and access services;

4) Prenatal education or health education;

5) Referral for services such as Women, Infants and Children (WIC);

6) Assistance to ensure client compliance with services prescribed/recommended by the Maternal and Child Health Provider (such as, substance abuse treatment, Early Intervention services, psychiatric services/mental health, specialty care); and

7) Outreach and case finding.

(Source: Amended at 20 Ill. Reg. 4345, effective March 4, 1996)

Section 140.924 Maternal and Child Health Provider Participation Requirements

a) Primary Care Providers

1) Basic Requirements
Maternal and Child Health primary care providers may include physicians, Advanced Practice Nurses meeting all requirements set forth in Section 140.435, Federally Qualified Health Centers (FQHCs), hospital clinics per Section 140.461(f) and encounter rate clinics per Section 140.461(b). Maternal and Child Health providers shall meet the qualifications (see Section 140.12) as are applicable for all medical providers under the Illinois Medical Assistance Program, and, with the exception of APNs, shall meet all of the following requirements:

A) maintain hospital admitting privileges;

B) maintain delivery privileges if providing care to pregnant women;

C) be enrolled and in good standing with the Medical Assistance Program; and

D) complete a Maternal and Child Health Primary Care Provider Agreement, or have been enrolled as a provider under the Healthy Moms/Healthy Kids Program, in which they agree to:

i) provide periodic health screening (EPSDT), including age appropriate immunizations, and primary pediatric care as needed for children served in their practice, consistent with guidelines published by the American Academy of Pediatrics or American Academy of Family Physicians;

ii) provide obstetrical care and delivery services as appropriate for pregnant women served through their practice, consistent with guidelines published by the American College of Obstetricians and Gynecologists or the American Academy of Family Physicians;

iii) provide risk assessments for pregnant women and/or children;

iv) provide medical care coordination, including arranging for diagnostic consultation and specialty care;

v) communicate with the case management entity;

vi) maintain 24-hour telephone coverage for assessment and consultation; and

vii) provide equal access to quality medical care for assigned clients.

AGENCY NOTE: FQHCs are federally exempt from subsections (a)(1)(A) and (B).

2) Advanced Practice Nurse Requirements

A) The requirements described in subsections (a)(1)(A) and (B) of this Section apply to the physician or practitioner with whom the APN has a collaborative or written practice agreement.

B) The requirements described in subsections (a)(1)(C) and (D) of this Section apply to the enrolled APN.

3) Special Requirements
In addition to the basic requirements described in subsection (a)(1), encounter rate clinics as Maternal and Child Health providers shall be required to meet the following additional requirements:

A) Meet the qualifications for an encounter rate clinic, as described in Section 140.461(b); and

B) Be owned, operated, managed, or staffed by a hospital that also operates a Maternal and Child Health clinic, as described in Section 140.461(f), or be located in a county with a population exceeding 3,000,000 that is part of an organized clinic system consisting of 15 or more individual practice locations, of which at least 12 are Federally Qualified Health Centers, as defined in Section 140.461(d).

4) The Department will consider requests from physicians who are unable to meet the hospital admitting privileges criteria for enrollment in the Maternal and Child Health Program if the physician has executed a formal agreement with another physician to accept referrals for hospital admissions. Requests will also be considered from physicians who do not

have delivery privileges but wish to provide obstetrical care. The request will be reviewed by the Department or its designee to determine whether the physician should be enrolled as a PCP into the Program. At the discretion of the Department or its designee, the requesting physician may be asked to appear for an interview and/or an on-site visit may be made by the Department or its designee. For consideration to be given, the requesting physician must submit the following information and supporting documentation in a format specified by the Department or its designee that provides the following:

A) Complete name, mailing address, Illinois practice license number and Medicaid provider number, if any;

B) Declared practice specialty;

C) Listing of all practice locations;

D) Name and location of hospitals applied to for admitting privileges;

E) Status of each request, i.e., pending or closed (if closed, a reason must be given by the hospital for not granting privileges);

F) If application has never been made, a statement explaining why;

G) Name of physician with whom a formal agreement has been effected;

H) Illinois license number of Medicaid enrolled physician with hospital admitting privileges and name of hospitals where admitting privileges are in effect; and

I) Copy of formal agreement.

5) The request is to be dated by the provider and forwarded to the Department of Healthcare and Family Services, Provider Participation Unit, P.O. Box 19114, Springfield, Illinois 62794-9114.

b) Case Management Providers
Case management providers' qualifications shall be in accordance with 77 Ill. Adm. Code 630. Case management will be provided to ensure access to medical care and better compliance with medical recommendations.

(Source: Amended at 30 Ill. Reg. 796, effective January 1, 2006)

Section 140.926 Client Eligibility (Repealed)

(Source: Repealed at 20 Ill. Reg. 4345, effective March 4, 1996)

Section 140.928 Client Enrollment and Program Components (Repealed)

(Source: Repealed at 20 Ill. Reg. 4345, effective March 4, 1996)

Section 140.930 Reimbursement

a) Reimbursement Rates for Maternal and Child Health Providers

1) Participating providers described in Section 140.924(a)(1) will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.

2) Participating FQHC's, as described in Section 140.461(d), that meet the criteria specified in 140.924(a)(2)(A), shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.

3) Participating encounter rate clinics shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.

4) Participating Maternal and Child Health clinics, as described in Sections 140.924 and 140.461(f), will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.

5) Participating providers described in Section 140.924(a)(1) shall be eligible to receive a Well Child Visit Incentive Payment.

A) The provider will receive a one time annual payment of $30 for each qualifying child.

B) A qualifying child is a child who had its first, second, third, fourth or fifth birthday during the calendar year and for whom the provider personally, or through an affiliated provider, rendered all recommended well child visits, as described in Section 140.488.

C) Recommended services must be rendered during the 13-month period ending one month after the child's birthday. For children turning one year old, the period begins ten days after birth and ends one month after the child's birthday. Rendering of services will be based on Department claims data.

D) The first incentive payments shall be made by June 30, 2007 for children who met the definition of a qualifying child during

calendar year 2005. Subsequent payments will be made at least annually.

E) For the purpose of payments under this Section, "affiliated provider" shall mean:

i) For qualifying children during calendar year 2005 through 2007, a provider with the same payee in accordance with Section 140.24(d).

ii) For qualifying children during calendar year 2008 and later, providers designated pursuant to Section 140.994.

b) Patient Management Fee
Providers who have accepted primary care responsibilities for foster children residing in Cook County who are under the guardianship of the Department of Children and Family Services will receive a monthly patient management fee for each client enrolled with them.

c) Case Management Services
Providers of case management services will receive monthly payments. The payments will be prorated based upon an annual amount per case.

(Source: Amended at 31 Ill. Reg. 14749, effective October 22, 2007)

Section 140.932 Payment Authorization for Referrals (Repealed)

(Source: Repealed at 20 Ill. Reg. 4345, effective March 4, 1996)

SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

Section 140.940 Illinois Competitive Access and Reimbursement Equity (ICARE) Program (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.5 at 12 Ill. Reg. 7401)

Section 140.942 Definition of Terms (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.25 at 12 Ill. Reg. 7401)

Section 140.944 Notification of Negotiations (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.50 at 12 Ill. Reg. 7401)

Section 140.946 Hospital Participation in ICARE Program Negotiations (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.75 at 12 Ill. Reg. 7401)

Section 140.948 Negotiation Procedures (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.100 at 12 Ill. Reg. 7401)

Section 140.950 Factors Considered In Awarding ICARE Contracts (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.105 at 12 Ill. Reg. 7401)

Section 140.952 Closing an ICARE Area (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.125 at 12 Ill. Reg. 7401)

Section 140.954 Administrative Review (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.150 at 12 Ill. Reg. 7401)

Section 140.956 Payments to Contracting Hospitals (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.175 at 12 Ill. Reg. 7401)

Section 140.958 Admitting and Clinical Privileges (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.200 at 12 Ill. Reg. 7401)

Section 140.960 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.205 at 12 Ill. Reg. 7401)

Section 140.962 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.225 at 12 Ill. Reg. 7401)

Section 140.964 Contract Monitoring (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.250 at 12 Ill. Reg. 7401)

Section 140.966 Transfer of Recipients (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.275 at 12 Ill. Reg. 7401)

Section 140.968 Validity of Contracts (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.300 at 12 Ill. Reg. 7401)

Section 140.970 Termination of ICARE Contracts (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.305 at 12 Ill. Reg. 7401)

Section 140.972 Hospital Services Procurement Advisory Board (Recodified)

(Source: Recodified to 89 Ill. Adm. Code 149.325 at 12 Ill. Reg. 7401)

SUBPART I: PRIMARY CARE CASE MANAGEMENT PROGRAM

Section 140.990 Primary Care Case Management Program

The Primary Care Case Management Program (PCCM) is a managed care model in which each enrollee has a medical home with a Primary Care Provider (PCP). Enrollees may pick their own doctor or clinic as their PCP if that provider is enrolled with HFS as a PCP. A medical home ensures that a single PCP knows about health care their enrollees receive and helps ensure enrollees get immunizations and other preventive health care, prevents duplication of services, ensures enrollees receive the most appropriate level of care, provides specialty referrals where appropriate, and improves the quality of care that an enrollee receives.

(Source: Added at 31 Ill. Reg. 388, effective December 29, 2006)

Section 140.991 Primary Care Provider Participation Requirements

a) Providers eligible to be Primary Care Providers (PCPs) are physicians, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), school-based/linked clinics, certified local health departments, hospital clinics per Section 140.461(f), and Encounter Rate Clinics (ERCs) per Section 140.461(b).

b) PCPs shall meet the qualifications (see Section 140.12) that are applicable for all medical providers under the Illinois Medical Assistance Program.

c) PCPs shall:

1) Establish and maintain hospital admitting and/or delivery privileges or arrangements for admission to a nearby hospital;

2) Complete, sign, and comply with terms of the Department's Primary Care Provider Agreement;

3) Provide to the patients enrolled with them under the PCCM program:

A) Periodic health screening (EPSDT), including age appropriate immunizations, and primary pediatric care as needed for children served in their practice;

B) Obstetrical care and delivery services as appropriate for pregnant women within the scope of their practice;

C) Provide risk assessments for pregnant women and/or children;

D) Provide medical care coordination, including arranging for diagnostic consultation and specialty care and communicating with the case management entity;

E) Maintain 24-hour telephone coverage for assessment and consultation.

Section 140.992 Populations Eligible to Participate in the Primary Care Case Management Program

a) Individuals enrolled in programs administered by the Department under Article V of the Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, or the Veterans' Health Insurance Program Act and not excluded by subsection (b) or (c) of this Section are eligible to participate in the Primary Care Case Management (PCCM) program.

b) Excluded populations are:

1) Individuals covered by Medicare;

2) Children under age 21 receiving Supplemental Security Income (SSI);

3) Department of Children and Family Services (DCFS) wards and individuals participating in the Subsidized Guardianship or Adoption Assistance programs;

4) Children under age 21 covered under the Aid to the Aged, Blind and Disabled (AABD) program;

5) Residents of nursing facilities;

6) American Indian/Alaska natives;

7) Spend-down individuals;

8) Persons enrolled in the following Home and Community Based Services (HCBS) Waiver Programs:

A) Adults with developmental disabilities (DD);

B) Residential waiver for children and young adults with DD;

C) Support waiver for children and young adults with DD;

D) Persons with brain injury;

E) Persons with HIV or AIDS;

F) Supportive living facilities;

G) Persons who are elderly (age 60-64); and

H) Children who are medically fragile/technology dependent;

9) Individuals in community integrated living arrangements (CILAs);

10) Individuals in presumptive eligibility programs;

11) Refugees;

12) Children, under the age of 21, who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act or whose care is otherwise managed by the Division of Specialized Care for Children of the University of Illinois at Chicago or the Department;

13) Individuals enrolled in the following programs with limited benefits:

A) Illinois Healthy Women;

B) All Kids Rebate and FamilyCare Rebate;

C) Illinois Cares Rx;

D) Transitional Assistance, age 19 or older;

E) Emergency Medical Only;

F) Hospice; and

G) Sexual Assault, Renal, and Hemophilia programs.

c) Populations already managed are:

1) Individuals with high level Third Party Liability (TPL) private insurance; and

2) Individuals in the Program for All-Inclusive Care for the Elderly (PACE) participants.

(Source: Amended at 34 Ill. Reg. 516, effective January 1, 2010)

Section 140.993 Care Management Fees

a) The Department shall pay Primary Care Providers (PCPs) enrolled in the Primary Care Case Management (PCCM) program the monthly care management fees set forth in subsection (b) of this Section for each individual enrolled with the PCP by the Department as of the beginning of the month. Such payments shall be made by the end of the month for which payment is being made.

b) Monthly care management fees are:

1) $2.00 for children under age 21;

2) $3.00 for non-disabled non-elderly adults; and

3) $4.00 for disabled or elderly adults.

c) August 2006 is the first month for which Federally Qualified Health Centers (FQHCs) and Encounter Rate Clinics (ERCs) enrolled as PCPs are eligible to receive care management fees.

d) September 2006 is the first month for which Rural Health Centers (RHCs) enrolled as PCPs are eligible to receive care management fees.

e) January 2007 is the first month for which all other PCPs in Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will counties are eligible to receive care management fees.

f) February 2007 is the first month for which all other enrolled PCPs in Boone, Bureau, Carroll, DeKalb, Fulton, Henderson, Henry, JoDaviess, Knox, LaSalle, Lee, Marshall, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago, and Woodford counties will be eligible to receive care management fees.

g) April 2007 is the first month for which all other enrolled PCPs in the remainder of the State are eligible to receive care management fees.

(Source: Added at 31 Ill. Reg. 388, effective December 29, 2006)

Section 140.994 Panel Size and Affiliated Providers

a) PCPs may designate to the Department those providers who provide primary care coverage for the PCP's patients when the PCP is unavailable. Providers so designated will not need a referral in order to be reimbursed by the Department for services provided to that PCP's patients.

b) The Department shall limit the number of patients enrolled with a PCP to 1,800. A PCP practicing with an Advanced Practice Nurse (APN), Physician's Assistant (PA) or Resident may have his or her panel size increased by 900 patients for each Full Time Equivalent APN, PA or Resident in his or her practice. The limit on the number of patients enrolled with a clinic that is allowed to enroll as a PCP shall be based on the number of Full Time Equivalent physicians, APNs or PAs within the site.

c) A PCP may limit his or her panel to a specified number of patients less than the maximum number set forth in this Section, may limit that panel to only his or her existing patients or existing patients and their family members, and may limit patients by age or other factors relevant to the scope of his or her practice.

d) In areas where there is an insufficient number of PCPs to adequately serve the population eligible to enroll in the PCCM program without exceeding the panel limits established in subsection (b), the Department may allow APNs to enroll as PCPs or allow PCPs to exceed the limit established in subsection (b) of this Section.

e) A PCP may decline to have patients auto-assigned to him or her who have not chosen that PCP.

(Source: Amended at 34 Ill. Reg. 516, effective January 1, 2010)

Section 140.995 Mandatory Enrollment

a) Effective on the dates set forth in subsection (e) of this Section, individuals enrolled in programs administered by the Department under Article V of the Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, or the Veterans' Health Insurance Program Act and not excluded in Section 140.992(b) who are not enrolled in a Managed Care Organization must enroll with a PCP.

b) HFS shall send a notice to each individual for whom enrollment in the PCCM program is mandatory, notifying the individual of the need to enroll with a Primary Care Provider and explaining the options for doing so, and, where available, the options for enrolling with a PCP within a Managed Care Organization (MCO). If the individual has not chosen a PCP within 30 days after the date of the first notice, the Department shall send a second notice to the individual instructing him or her to choose a PCP and informing the individual that the Department will assign him or her to a PCP in the PCCM program if he or she does not choose one.

c) Individuals who have not chosen a PCP within 60 days after the date of their first notice shall be assigned by HFS to a PCP in the PCCM program in their service area. The algorithm used in the default enrollment process shall be in compliance with 42 CFR 438.50. The individuals will be mailed a notice to inform them of their assigned PCP. Assignment to a PCP shall be effective no sooner than 60 days after the date that the first notice is mailed by the Department.

d) An individual and the PCP with whom that individual is enrolled will receive notice of the enrollment. Enrollment information will be available the day following the enrollment through internet-based and electronic eligibility verification systems.

e) Mandatory enrollment shall be phased in effective with the dates set forth in this subsection.

1) The Department will send notices to individuals living in Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will counties beginning no sooner than February 2007.

2) The Department will send notices to individuals living in Boone, Bureau, Carroll, DeKalb, Fulton, Henderson, Henry, JoDaviess, Knox, LaSalle, Lee, Marshall, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago, and Woodford

counties beginning no sooner than March 2007.

3) The Department will send notices to individuals living in the remainder of the State beginning no sooner than April 2007.

f) Individuals may change PCPs within the PCCM program once per calendar month. Changes shall be effective no later than the fourth day after the request for change is registered with the Department or its agent. In counties where managed care organizations operate, an individual enrolled in the PCCM program may disenroll from the PCCM program and enroll in a managed care organization, and an individual enrolled in a managed care organization may disenroll from the managed care organization and enroll in the PCCM program. Such enrollments shall be effective no later than the first day of the second month following the month in which the enrollee files the request.

g) Individuals living in a service area where there is no PCP available with capacity for an enrollment are excluded from mandatory enrollment requirements.

h) PCPs may request that an individual assigned to them be disenrolled from them in accordance with 42 CFR 438.56.

i) If an individual enrolled in the PCCM program loses Medical Assistance eligibility and his or her Medical Assistance eligibility is reinstated within 60 days, that individual will be assigned to the PCP to whom assigned when Medical Assistance eligibility terminated.

j) If a PCP in the PCCM Program is terminated or otherwise becomes unavailable, an individual in the PCCM Program who is enrolled with that PCP may access any Medicaid enrolled provider until that member is enrolled in a new PCP.

(Source: Added at 31 Ill. Reg. 6930, effective April 29, 2007)

Section 140.996 Access to Health Care Services

a) With the exception of those direct access services identified in subsection (b), individuals enrolled with a PCP may only access health care services from that PCP, or a provider designated to the Department as affiliated with that PCP, or a provider to whom that PCP has referred those individuals.

b) Individuals enrolled with a PCP do not need a referral in order to access the services determined to be direct access by the Department. These services include:

1) Services provided to newborns up to 91 days after birth

2) Family Planning and Obstetrical and Gynecological (OB/Gyn) Services

3) Inpatient and Outpatient Hospital Services

4) Shots/Immunizations

5) Emergency Services

6) Emergency and Non-Emergency Transportation

7) Pharmaceuticals

8) Dental Services

9) Vision Services

10) Therapies

11) Mental Health and Substance Abuse Services

12) Outpatient Ancillary Services (radiology, pathology, lab, anesthesia)

13) Services to Treat Sexually Transmitted Diseases and Tuberculosis

14) Early Intervention Services

15) Lead Screening and Epidemiological Services

16) Services provided in the following settings:

A) School-Based/Linked Clinics for Children under Age 21

B) School-Based Clinics through Local Education Authorities for Children under Age 21

C) Local Health Departments

D) Mobile Vans, with Department approval

E) FQHC Homeless Sites and Migrant Health Centers.

(Source: Added at 31 Ill. Reg. 6930, effective April 29, 2007)

Section 140.997 Payment for Services

Effective on or after July 1, 2007, for individuals enrolled with a PCP, providers other than the individual's PCP or providers affiliated with that PCP shall not be reimbursed for services that are not direct access services, unless the individual's PCP referred the individual to that provider and a referral has been registered with the Department.

(Source: Added at 31 Ill. Reg. 6930, effective April 29, 2007)

SUBPART J: ALTERNATE PAYEE PARTICIPATION

Section 140.1001 Registration Conditions for Alternate Payees

a) In order to participate, alternate payees must meet the following conditions:

1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical entities;

2) Be certified for participation in the Title XVIII Medicare program when federal or State rules and regulations require such certification for Title XIX participation;

3) Be certified for Title XIX when federal or State rules and regulations so require;

4) Qualify as:

A) Hospital or a hospital affiliate as defined by the Hospital Licensing Act [210 ILCS 85];

B) Professional school that offers a degree to qualify individuals for licensure to perform medical services;

C) Group practice solely owned by three or more full-time licensed individual practitioners who are eligible to participate in the Medical Assistance Program;

D) Partnership that requires fees of its partners to be turned over to the partnership and all partners are eligible to participate in the Medical Assistance Program;

E) Individual practitioner "employer" who requires an employee, as a condition of employment, to turn over his or her fees to the employer. The employer must be eligible to participate in the Medical Assistance Program and, except as provided below, must be licensed in the same profession as the practitioners in his or her employ who have designated the employer as the alternate payee. The employer may only qualify as a payee for a total of four individual practitioners, including the employer. Practitioners may designate an employer who is a physician licensed under the Medical Practice Act of 1987 [225 ILCS 60] if the practitioner is

an advanced practice nurse licensed under the Nurse Practice Act [225 ILCS 65];

F) Corporation registered with the Illinois Secretary of State's Office to do business in the State of Illinois and whose shares of ownership are publicly traded in a recognized stock exchange within the United States of America;

G) Governmental entity that requires, as a condition of employment, that the fees be turned over to the governmental entity;

H) Community mental health agency that is certified by the Department of Human Services under 59 Ill. Adm. Code 132 and is enrolled as a provider in the Medical Assistance Program; or

I) Federally Qualified Health Center, Rural Health Center or Encounter Rate Clinic that is enrolled as a provider in the Medical Assistance Program;

5) Provide registration information to the Department, in the prescribed format;

6) Notify the Department, in writing, immediately whenever there is a change in any information that the alternate payee has previously submitted;

7) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to public assistance recipients and alternate payee relationships; and

8) Have a current alternate payee registration on file with the Department.

b) Approval of a corporate entity such as a group practice, a partnership, hospital, or professional school as an alternate payee in the Medical Assistance Program applies only to the entity's existing ownership, corporate structure, and location. Therefore, an alternate payee's registration in the Medical Assistance Program is not transferable.

c) For purposes of administrative efficiency, the Department may periodically

require classes of alternate payees to re-register in the Medical Assistance Program. Under such a re-registration, the Department shall request classes of alternate payees to submit updated information. Failure of an alternate payee to submit such information within the requested time frames may result in cancellation of the alternate payee registration from the Program. Such cancellation shall have no effect on the future eligibility of the alternate payee to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program.

d) For purposes of this Section, an alternate payee whose alternate payee investor ownership has changed by 50 percent or more from the date the alternate payee was initially approved for registration as an alternate payee in the Medical Assistance Program shall be required to submit a new application for registration. All such applications must meet the requirements for registration.

(Source: Amended at 32 Ill. Reg. 17133, effective October 15, 2008)

Section 140.1002 Participation Requirements for Alternate Payees

In order for an individual practitioner to designate that payments that may be due to the practitioner be made to a specific alternate payee, there must be a written alternate payee agreement between the individual practitioner and that alternate payee. This alternate payee agreement, which must be on file with the Department, shall be in the form and manner prescribed by the Department. In executing such an alternate payee agreement, an alternate payee shall agree to:

a) Comply with the Department's policies, rules and regulations, and with the terms and conditions prescribed by the Department in its alternate payee registration and alternate payee agreements;

b) Comply with the requirements of applicable federal and State laws and not engage in practices prohibited by those laws;

c) Hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding recipients;

d) Furnish to the Department, in the form and manner requested by the Department, any information it requests regarding payments in connection with the rendering of goods or services or supplies to recipients by the provider or his or her agent, employer or employee; and

e) Ensure maintenance of any and all professional records that relate to the quality of care given by the provider and that document the care for which payment is claimed for the designated alternate payee.

(Source: Added at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.1003 Recovery of Money for Alternate Payees

a) An individual practitioner and its designated alternate payee shall be jointly and severally liable to the Department for payments made to the alternate payee on behalf of that individual practitioner.

b) Department action to recover money or overpayments from an alternate payee shall be subject to an administrative hearing pursuant to 89 Ill. Adm. Code 104.200, Subpart C, Medical Vendor and Alternate Payee Hearings.

(Source: Added at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.1004 Conditional Registration for Alternate Payees

a) Registration as an alternate payee in the Illinois Medical Assistance Program shall be conditional. At any time, the Department may deny or cancel an alternate payee's registration in the Illinois Medical Assistance Program without cause. Any such denial or cancellation is not subject to an administrative hearing. Upon cancellation, payments shall cease to the alternate payee.

b) The Department shall provide written notice of denial or cancellation. Any payments made by the Department after a cancellation notice to a designated alternate payee may be recoverable from the alternate payee pursuant to Section 140.15.

c) An alternate payee whose registration has been cancelled may no longer act as a provider's designated payee.

(Source: Added at 31 Ill. Reg. 2413, effective January 19, 2007)

Section 140.1005 Revocation of an Alternate Payee

a) The Department may seek a revocation of any alternate payee that has participated in the Program, and all owners, officers, a partners, and individuals with management responsibility for the alternate payee shall be permanently prohibited from participating as an owner, an officer, a partner, or an individual with management responsibility with an alternate payee in the Illinois Medical Assistance Program if, after reasonable notice and opportunity for a hearing, the Department finds that:

1) the alternate payee is not complying with Department policy or rules, or with the terms and conditions prescribed by the Department in its alternate payee registration and alternate payee agreements; or

2) the alternate payee is not properly licensed or qualified, or the alternate payee's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated as determined by the appropriate licensing, certifying, or authorizing agency; or

3) the alternate payee has failed to make available for inspection, audit, or copying, after receiving a written request from the Department, records regarding payments claimed as an alternate payee; or

4) the alternate payee has failed to furnish any information requested by the Department regarding payments claimed as an alternate payee; or

5) the alternate payee has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Medical Assistance Program. For purposes of this Section, statements or representations made "knowingly" shall include statements or representations made with actual knowledge that they were false, as well as those statements made when the individual making the statement had knowledge of such facts or information as would cause one to be aware that the statements or representations were false when made; or

6) the alternate payee has submitted claims on behalf of an individual practitioner for services or supplies that were not rendered or delivered by the practitioner for which the alternate payee was designated; or

7) the alternate payee, a person with management responsibility for an

alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, a partner in a partnership alternate payee, or a member of a group practice alternate payee:

A) was previously terminated from participation in the Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of the Public Aid Code; or

B) was a person with management responsibility of a vendor previously terminated from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked or prohibited as an alternate payee in the Illinois Medical Assistance Program, or was terminated from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of the Public Aid Code, during the time of conduct that was the basis for that vendor's termination or alternate payee's revocation; or

C) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor previously terminated from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked or prohibited as an alternate payee in the Illinois Medical Assistance Program, or was terminated from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of the Public Aid Code, during the time of conduct that was the basis for that vendor's termination; or

D) was an owner of a sole proprietorship or partner in a partnership or a member in a group practice previously terminated from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked or prohibited as an alternate payee in the Illinois Medical Assistance Program, or was terminated from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of

medical assistance provided under Article V of the Public Aid Code, during the time of conduct that was the basis for that vendor's termination or alternate payee's revocation; or

8) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, a partner in a partnership alternate payee or a member in a group practice alternate payee:

A) has engaged in conduct prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

B) was a person with management responsibility for a vendor or alternate payee at the time the vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

C) was an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor or alternate payee at the time the vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

D) was an owner of a sole proprietorship, partner of a partnership, or member in a group practice that was a vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

i) For purposes of subsection (a)(8) of this Section, "applicable federal or State law or regulation" shall include licensing or certification standards contained in State or federal law or regulation related to the Medical Assistance Program, any other licensing standards as they related to the alternate payee's practice or business or any federal or State law or regulation related to the Medical Assistance Program;

ii) For purposes of subsection (a)(8) of this Section,

conviction or a plea of guilty to activities in violation of applicable federal or State law or regulation shall be conclusive proof that such activities were engaged in; or

9) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, a partner in a partnership alternate payee, or a member of a group practice alternate payee, has been convicted in this or any other State, or in any federal court, of any felony related to the Medical Assistance Program; or

10) the direct or indirect ownership of the vendor or alternate payee (including the ownership of a vendor or alternate payee that is a partner's interest in a vendor or alternate payee, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor or alternate payee) has been transferred by an individual who is terminated or barred from participating as a vendor or is prohibited or revoked as a alternate payee to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(Source: Added at 31 Ill. Reg. 2413, effective January 19, 2007)

SUBPART K: MANDATORY MCO ENROLLMENT

Section 140.1010 Mandatory Enrollment in MCOs

a) To the extent allowed by federal law and regulations, the Department may require individuals to enroll with a Managed Care Organization (MCO) under contract with the Department and to receive some or all of their medical benefits through that MCO.

b) HFS shall send a notice to each individual for whom enrollment in a MCO is mandatory, notifying the individual of the need to enroll with an MCO and explaining the options for doing so. If the individual has not chosen an MCO within 30 days after the date of the first notice, the Department shall send a second notice to the individual that the Department will assign him or her to an MCO if he or she does not choose one.

c) Individuals who have not chosen an MCO within 60 days after the date of their first notice shall be assigned to an MCO by HFS. The algorithm used in the default enrollment process shall be in compliance with 42 CFR 438.50. The individuals will be mailed a notice to inform them of their assigned MCO. Assignment to an MCO shall be effective no sooner than 60 days after the date that the first notice is mailed by the Department. An individual and the MCO with whom that individual is enrolled will receive notice of the enrollment.

d) Individuals may change MCOs within the first 90 days after the effective date of their enrollment. An individual who changes enrollment within the first 90 days may change MCO again within 90 days after enrollment in the second MCO. After the first 90 days or, in the case of an individual who changed twice, after the second enrollment, an individual may not change his or her enrollment until the end of the 12-month period following enrollment in the current plan.

e) If an individual enrolled in an MCO loses Medical Assistance eligibility and his or her Medical Assistance eligibility is reinstated within 60 days, that individual will be enrolled with the MCO with which he or she was enrolled when Medical Assistance eligibility terminated.

f) In circumstances in which an individual does not have a choice of MCO, the procedures outlined in subsections (b) through (e) shall be followed for choosing a primary care provider.

g) For purposes of this Section, Managed Care Organization includes any entity with a contract for a Care Coordination Program pursuant to Section 5-30 of the Public

Aid Code [305 ILCS 5/5-30], Section 23 of the Children's Health Insurance Program Act [215 ILCS 106/23] or Section 56 of the Covering All Kids Health Insurance Act [215 ILCS 170/56]. Any contract subject to this Section shall have outcome measures, enrollee protections to assure quality and access, and financial accountability for the contractor based on quality measures.

(Source: Added at 35 Ill. Reg. 7648, effective May 1, 2011)

Section 140.TABLE A Medichek Recommended Screening Procedures (Repealed)

(Source: Repealed at 15 Ill. Reg. 298, effective December 28, 1990)

Section 140.TABLE B Geographic Areas

These geographic areas define boundaries, according to counties, that are used in rate setting for long term care facilities. Geographic areas are referenced in Sections 140.555, 140.560, 140.561 and 140.578, 89 Ill. Adm. Code 144 and 89 Ill. Adm. Code 147.

a) North Suburb - Kane, Lake and McHenry.

b) Chicago 1 – City of Chicago.

c) Chicago 2 – Cook (Other than Chicago) and DuPage.

d) South Suburb – Grundy, Kankakee, Kendall and Will.

e) South 1 – Alexander, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White and Williamson.

f) South 2 – Bond, Clinton, Madison, Monroe and St. Clair.

g) Central 1 – Bureau, Fulton, Henderson, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, Warren and Woodford.

h) Central 2 – Adams, Brown, Calhoun, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Pike, Sangamon, Schuyler and Scott.

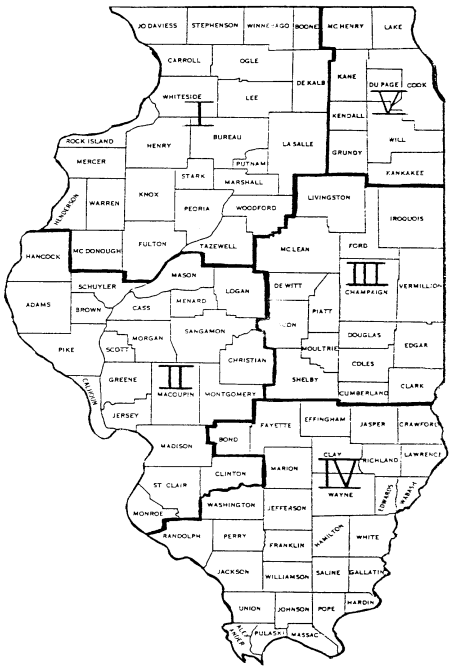
i) Central 3 – Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby and Vermilion.

j) Northwest 1 – Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago.

k) Northwest 2 – Henry, Mercer and Rock Island.

(Source: Amended at 21 Ill. Reg. 9763, effective July 15, 1997)

Section 140.TABLE C Capital Cost Areas



Section 140.TABLE D Schedule of Dental Procedures

a) Diagnostic Services

1) Clinical Oral Examinations

A) Periodic oral evaluation, ages 0-20 years, once every 12 months

B) Limited oral examination-problem focused in conjunction with an emergency visit

C) Comprehensive oral examination, once per patient, per lifetime, per dentist or group

2) Radiographs

A) Intraoral, complete series (including bitewings), once per 36 months, complete series every 36 months

B) Intraoral – periapical – first film, maximum of one per day, per provider or group

C) Intraoral – periapical – additional film, maximum of five per day

D) Bitewing – single film

E) Bitewings – two films

F) Bitewings – four films

G) Vertical bitewings – 7-8 films

H) Panoramic film, one per 36 months

b) Preventive Services

1) Prophylaxis, ages 2-20 years, once every 6 months

2) Topical application of fluoride , ages 2-20 years, once every 12 months

3) Sealant – per tooth, ages 5-17 years, occlusal surfaces of the permanent first and second molars, once per lifetime

4) Space maintainer – fixed unilateral, ages 2-20 years

5) Space maintainer – fixed bilateral, ages 2-20 years

6) Space maintainer – removable bilateral type, ages 2-20 years

7) Recementation of space maintainer, ages 2-20 years

c) Restorative Services

1) Amalgam Restorations

A) Amalgam – 1 surface, primary

B) Amalgam – 2 surfaces, primary

C) Amalgam – 3 surfaces, primary

D) Amalgam - 4 plus surfaces, primary

E) Amalgam – 1 surface, permanent

F) Amalgam – 2 surfaces, permanent

G) Amalgam – 3 surfaces, permanent

H) Amalgam – 4 plus surfaces, permanent

2) Composite Restorations

A) Resin – based composite – 1 surface, anterior

B) Resin – based composite – 2 surfaces, anterior

C) Resin – based composite – 3 surfaces, anterior

D) Resin – based composite – 4 or more surfaces, or including the incisal edge

E) Resin – based composite – 1 surface, posterior, primary

F) Resin – based composite – 2 surfaces, posterior, primary

G) Resin – based composite – 3 or more surfaces, posterior, primary

H) Resin – based composite – 1 surface, posterior, permanent

I) Resin – based composite – 2 surfaces, posterior, permanent

J) Resin- based composite – 3 surfaces, posterior, permanent

K) Resin – based composite – 4 or more surfaces, posterior, permanent

3) Other Restorative

A) Crown – porcelain/base metal

B) Crown – full cast base metal

C) Prefabricated stainless steel crown, primary tooth, ages 2-20 years

D) Prefabricated stainless steel crown, permanent tooth, ages 2 years and over

E) Prefabricated resin crown, ages 2 years and over

F) Sedative fillings

G) Pin retention – per tooth

H) Prefabricated post and core

I) Recement inlays

J) Recement crown

d) Endodontic Services

1) Therapeutic pulpotomy, primary teeth only, ages 2-20 years

2) Root canal therapy (including exam, clinical procedure, necessary radiographs and follow up)

A) Anterior root canal (excluding final restoration), ages 2 years and over

B) Bicuspid root canal (excluding final restoration), ages 2-20 years

C) Molar root canal (excluding final restoration), ages 2-20 years

D) Apexification/recalcification, initial visit, ages 2-20 years

E) Apexification/recalcification, interim visit, ages 2-20 years

F) Apexification/recalcification, final visit, ages 2-20 years

G) Apicoectomy/periradicular surgery – per tooth, first root, ages 2-20 years

e) Periodontic Services
Periodontal Treatment

1) Gingivectomy or gingivoplasty – per quadrant, ages 0-20 years

2) Gingivectomy or gingivoplasty – per tooth, ages 0-20 years

3) Gingival flap procedure, including root planing – per quadrant, ages 0-20 years

4) Osseous surgery – per quadrant, ages 0-20 years

5) Bone replacement graft – first site in quadrant, ages 0-20 years

6) Bone replacement graft – each additional site in quadrant, ages 0-20 years

7) Pedicle soft tissue graft, ages 0-20 years

8) Free soft tissue graft, ages 0-20 years

9) Subepithelial connective tissue graft procedure, ages 0-20 years

10) Distal or proximal wedge procedure, ages 0-20 years

11) Provisional splinting, intracoronal, ages 0-20 years

12) Provisional splinting, extracoronal, ages 0-20 years

13) Periodontal scaling and root planing – per quadrant, ages 0-20 years

14) Periodontal maintenance procedure, ages 0-20 years

f) Removable Prosthodontic Services (every five years based on age of prior placement)

1) Complete Dentures – including six months' post delivery care

A) Complete denture – maxillary

B) Complete denture – mandibular

C) Immediate denture – maxillary

D) Immediate denture – mandibular

2) Partial Dentures – including six months' post delivery care

A) Maxillary partial denture – resin base, ages 2-20 years

B) Mandibular partial denture – resin base, ages 2-20 years

C) Maxillary partial denture – cast metal framework, ages 2-20 years

D) Mandibular partial denture – cast metal framework, ages 2-20 years

3) Repairs to Dentures

A) Repair complete denture

B) Replace missing or broken teeth, complete denture (each tooth)

C) Repair partial denture base

D) Repair cast framework

E) Repair or replace broken clasp

F) Replace broken teeth, per tooth

G) Add tooth to existing partial

4) Denture Reline Procedures (covered once every 24 months)

A) Reline complete maxillary denture, chairside

B) Reline complete mandibular denture, chairside

C) Reline maxillary partial denture, chairside

D) Reline mandibular partial denture, chairside

E) Reline complete maxillary denture, laboratory

F) Reline complete mandibular denture, laboratory

G) Reline maxillary partial denture, laboratory

H) Reline mandibular partial denture, laboratory

5) Maxillofacial Prosthetics

A) Facial moulage – sectional

B) Facial moulage – complete

C) Nasal prosthesis

D) Auricular prosthesis

E) Orbital prosthesis

F) Ocular prosthesis

G) Facial prosthesis

H) Nasal septal prosthesis

I) Ocular prosthesis, interim

J) Cranial prosthesis

K) Facial augmentation implant prosthesis

L) Nasal prosthesis, replacement

M) Auricular prosthesis, replacement

N) Orbital prosthesis, replacement

O) Facial prosthesis, replacement

P) Obturator prosthesis, surgical

Q) Obturator prosthesis, definitive

R) Obturator prosthesis, modification

S) Mandibular resection, prosthesis with guide flange

T) Mandibular resection, prosthesis without guide flanges

U) Obturator prosthesis, interim

V) Trismus appliance

W) Feeding aid

X) Speech aid prosthesis

Y) Palatal augmentation prosthesis

Z) Palatal lift prosthesis, definitive

AA) Palatal lift prosthesis, interim

BB) Palatal lift prosthesis, modification

CC) Speech aid prosthesis, modification

DD) Surgical stent

EE) Radiation carrier

FF) Radiation shield

GG) Radiation cone locator

HH) Fluoride gel carrier

II) Commissure splint

JJ) Surgical splint

KK) Unspecified maxillofacial prosthesis

g) Fixed Prosthetic Services

1) Bridge Pontics

A) Pontic – porcelain fused to predominantly base metal, ages 2-20 years

B) Pontic – resin with predominantly base metal, ages 2-20 years

2) Bridge Retainer Crowns

A) Crown – resin with predominantly base metal, ages 2-20 years

B) Crown-porcelain with predominantly base metal, ages 2-20 years

3) Other Prosthetic Services

A) Recement fixed partial denture

B) Prefabricated post and core in addition to fixed partial denture retainer, ages 2-20 years

h) Oral and Maxillofacial Services

1) Simple Extractions

A) Single tooth extraction

B) Each additional extraction

C) Root removal, exposed roots

2) Surgical Extractions

A) Surgical removal of erupted tooth

B) Removal of impacted tooth – soft tissues

C) Removal of impacted tooth – partially bony

D) Removal of impacted tooth – completely bony

E) Surgical removal of residual roots

3) Other Surgical Procedures
Surgical exposure to aid eruption, ages 2-20 years

4) Alveoloplasty

A) Alveoloplasty in conjunction with extractions, ages 2-20 years

B) Alveoloplasty not in conjunction with extractions, ages 2-20 years

5) Removal of Cysts and Neoplasms

A) Removal of odontogenic cyst or tumor, up to 1.25 cm

B) Removal of odontogenic cyst or tumor, over 1.25 cm

C) Removal of non-odontogenic cyst or tumor, up to 1.25 cm

D) Removal of non-odontogenic cyst or tumor, over 1.25 cm

E) Incision and drainage of abscess

6) Treatment of Fractures – Simple

A) Maxilla – open reduction, teeth immobilized

B) Maxilla – closed reduction, teeth immobilized

C) Mandible – open reduction, teeth immobilized

D) Mandible – closed reduction, teeth immobilized

7) Treatment of Fractures – Compound

A) Maxilla – open reduction

B) Maxilla – closed reduction

C) Mandible – open reduction

D) Mandible – closed reduction

8) Reduction of Dislocation

A) Open reduction of dislocation

B) Closed reduction of dislocation

9) Other Oral Surgery
Frenulectomy – separate procedure (frenectomy or frenotomy), ages 2-20 years

i) Orthodontic Services – for ages 2-20 years

1) Initial examination, records, study models, radiographs, and facial photographs, ages 2-20 years

2) Initial orthodontic appliance placement, ages 2-20 years

3) Monthly adjustments, ages 2-20 years

4) Initial orthodontic evaluation/study models, ages 2-20 years (for cases that fail to reach 42 points on the Modified Salzmann Index).

j) Adjunctive General Services

1) Unclassified Treatment

A) Palliative (emergency) treatment of dental pain – minor procedures

B) General anesthesia

C) Analgesia, anxiolysis, inhalation of nitrous oxide

D) Intravenous sedation

2) Professional Consultation
Consultation (narrative; diagnostic services provided by dentist other than practitioner providing treatment)

3) Drugs

A) Therapeutic drug injection

B) Other drugs and medicaments

4) Miscellaneous Services
Unspecified procedure by report to be described by statement of attending dentist

(Source: Amended at 27 Ill. Reg. 14799, effective September 5, 2003)

Section 140.TABLE E Time Limits for Processing Prior Approval Requests

	Item/Service	Number of Days
1.	Routine transportation within Illinois or to facilities normally utilized by Illinois residents	10
2.	Supplies/sickroom needs costing less than $100	21
3.	Standard wheel chairs	21
4.	Standard hospital beds	21
5.	Specially-equipped hospital beds	21
6.	Custom wheel chairs	30
7.	Respiratory equipment	30
8.	Other durable equipment	30
9.	Braces, artificial limbs and other prosthetic devices	21
10.	Custom-built shoes and shoes to which a brace or other corrective device is attached	30
11.	Hearing aids	30
12.	In-patient hospital Physical rehabilitation services	30
13.	Supplies/sickroom needs over $100	30
14.	Transportation to remote facilities outside Illinois and extraordinary modes of transportation	21
15.	Physical therapy	30
16.	Speech therapy	30
17.	Occupational therapy	30
18.	Home Health Agency	21
19.	Intermittent services in the home by a registered nurse	24
20.	Private duty registered nurse service in a hospital	10
21.	Dental Services	30
22.	Dental Services for GA/AMI/Refugee Programs	30
23.	Eye Care Services	30
24.	Chiropractic Services	30
25.	Podiatric Services	30
26.	All other items or services requiring prior approval	30

(Source: Added (by codification with no substantive change) at 8 Ill. Reg. 17899)

Section 140.TABLE F Podiatry Service Schedule

a) Podiatric Medical Visits

1) Office Visits

A) Visit office – (new patient) evaluation, history, examination, with treatment

B) Visit office – (established patient) examination, evaluation and/or treatment, same or new illness

2) Home Visits

A) Visit home

B) Evaluation, history, examination and treatment

3) Hospital Visits

A) Visit hospital – (new or established patient) history and physical examination, including treatment

B) Extended Care Facilities, Convalescent Hospital Nursing Home, and Boarding Home Visits

C) Visit facility – (first patient seen) history and physical examination, including care or treatment

D) Visit facility – (coinciding visit) history and physical examination, including treatment of additional patient (e.g., a patient that is seen concurrently with other patient(s) during the doctor's visit at the facility).

4) Consultations
*Consultation of unusual complexity requiring review of prior medical records, the compilation and assessment of data and preparation of special report, at home, office or hospital

b) Podiatric Diagnostic Radiology – Definitions

1) Foot, single, limited, two views – 1 plate

2) Feet, both, limited, two views – 2 plates

3) Foot and ankle, complete, minimum of three views – 3 plates

c) Podiatric Pathology

1) Urinalysis

2) Urinalysis, routine, complete

3) Chemistry

4) Sugar (glucose), blood

5) Uric acid, blood, chemical

6) Hematology

7) Bleeding time

8) Blood count, complete (includes rbc, wbc, hgb, differential)

9) Coagulation time (Lee and White)

10) Sedimentation rate (esr)

11) Immunology

12) Latex fixation, rheumatoid factor

13) Microbiology

14) Microbial analysis, microscopic examination, stain for bacteria, fungi, parasites, inclusion bodies, etc.

15) Microbial analysis, fungi, microscopic and macroscopic (culture)

d) Physical Medicine
Any of the accepted physical therapy modalities when used in combination with an office visit.

e) Surgical Procedures

1) Integumentary System

A) Incision

B) Incision and drainage of subcutaneous abscess

C) Incision and drainage of onychia or paronychia with partial or total excision or avulsion of nail and with or without excision of granulation tissue

D) Incision and removal of foreign body, subungual or subcutaneous issues

E) Benign Lesions

F) **Excision of small neoplastic, cicatricial, inflammatory or congenital lesion of skin or subcutaneous tissue (e.g. verrucae, plantar keratosis, fibroma, etc.)

G) Nails

H) **Avulsion or excision of nail plate, partial or complete, simple

I) Excision of nail, nail bed, and/or nail fold with excision of matrix and plasty (onychectomy with plasty or onychoplasty), partial

J) Onychoplasty (onychectomy with plasty) total

K) Excision, complete (total) of nail bed and/or nail fold, with excision of matrix and with partial ostectomy of distal phalanx and plasty of toe (onychectomy with dactyloplasty or terminal Symes)

L) Destruction of nail root and matrix with partial excision of avulsion of nail using one of the following methods: Negative galvanism, electrocoagulation, fulguration or dessication, phenolization, cryocautery (CO2, N2), or with power surgical drill or burr

M) Same as above – total nail

N) Introduction

O) Injection of a corticosteroid solution to lesion(s)

P) Repair – Simple

Q) *Wound, repair of, (e.g., suture of, etc.)

R) Destruction

S) **Electrosurgical destruction, with or without surgical currettement of small, single lesion, (e.g., verruca, nevus, keratosis, etc.)

2) Specific

A) Incision

B) Tenotomy, subcutaneous, corrective

C) Tenoplasty for lengthening or shortening of tendon of toe, unilateral, (independent procedure)

D) Excision

E) Excision of peripheral neuroma (Morton's neuroma, neurofibroma, Schwannoma, etc.) of digit or interdigital regions of lesser toes, single

F) Excision of lesion of tendon or fibrous sheath or capsule (e.g., cyst or ganglion, etc.) from the foot

G) Excision of chondroma, exostosis, osteochondroma, osteoma, etc., from a tarsal bone, other than the calcaneus or talus, by open reduction.

H) Same as item above – from the calcaneus, by open reduction

I) Same as item above – from the calcaneus, by subcutaneous (percutaneous) technique using rasp or drill

J) Same as item above – from a phalangeal bone, subcutaneous method

K) Ostectomy, partial excision of fifth metatarsal head (e.g., bunionette, independent procedure)

L) Ostectomy, partial excision of metatarsal head (e.g., metatarsectomy, partial, such as a condylectomy or excision of head of metatarsal)

M) Ostectomy, partial excision of a phalanx (phalangectomy, partial such as condylectomy or excision or head or phalanx)

N) Ostectomy, partial, of calcaneus for Haglund's deformity

O) Phalangectomy, lesser toe, total

P) Sesamoidectomy (independent procedure and not part of a procedure for the repair of a hallux valgus)

Q) Capsulotomy, open, for contracture, metatarsophalangeal joint, with or without tenorrhaphy (independent procedure)

R) Same as item above – subcutaneous ("percutaneous") procedure (e.g., capsulotomy, with or without tenotomy of a metatorsophalangeal joint)

S) Hallux valgus, correction by exostectomy (e.g., Silver Type procedure or any modification thereof, etc.) unilateral

T) Same as item above – McBride or any modification thereof

U) Arthroplasty, metatarsophalangeal joint of great toe, (e.g., hallux valgus repair by Keller, Mayo, or Stone, etc., procedures with or without use of implant)

V) Osteotomy (e.g., cutting, division or transection of bone, with or without fixation. Independent procedure and/or part of a repair procedure for hallux valgus) for shortening or angular correction, (e.g., dorsal wedge osteotomy with internal fixation, base wedge osteotomy, extension osteoarthrotomy, etc.) of first metatarsal bone

W) Same as item above – for a lesser metatarsal bone, single, unilateral

X) Subcutaneous ("percutaneous") metaphyseal osteotomy (osteoclasis), first metatarsal, for shortening, angular, or rotational correction

Y) Same as item above – for a lesser metatarsal, single (percutaneous)

Z) Fracture and/or dislocation

AA) *Tibia or Fibula, ankle, closed (simple), without reduction

BB) *OS Calcis, fracture, closed (simple), without reduction

CC) *Astragalus talus, fracture, closed (simple), without reduction

DD) *Tarsal bone(s) (except astragalus or os calcis), fracture(s), closed (simple), without reduction

EE) *Metatarsal fracture, first metatarsal bone, closed (simple), without reduction

FF) *Metatarsal(s) (other than first metatarsal bone) fracture(s), closed (simple), without reduction

GG) *Phalanx or phalanges, fracture great toe, closed (simple), without reduction

HH) *Same as item above – other than great toe, without reduction

II) Metatarsal – phalangeal joint, dislocation, closed (simple), manipulative reduction requiring anesthesia

JJ) Interphalangeal joint, dislocation, closed (simple), manipulative reduction, requiring anesthesia

KK) Strapping

LL) Unna Boot

f) Orthomechanical Procedures

1) Metal Foot Plates

2) Shaeffer plate (custom made to model), pair

3) Roberts Foot plate (custom made to model), pair

4) Whitman Foot plate or brace (custom made to model), pair

5) Themoplastic Plates, (Biomechanical)

6) Stabilization and/or mobilization of foot by use of a thermoplastic orthotic (custom made to model and biomechanically), with forefoot post, pair

7) Molded Inlays (Balance Inlays)

8) The stabilization, balance and mobilization of the foot, partial or total by use of a full extension or partial molded inlay made to foot models with an elevation up to 3/4" and with a matching insert as an interior show modification. Removable type. (All types of balance inlays, Bergmann, Levy, Brachman, Contura, Molded Latex, etc.) Single with matching insert or a pair

9) Shoes

10) Custom made, to models, of contour or space shoes with interior modifications, pair

11) Shoe Modifications (exterior)

12) Stabilization and/or mobilization of foot by use of exterior modifications to shoes, such as orthopedic heals, comma bars, heel or sole wedges, etc., pair

13) Shoe Modifications, Interior (Shoe padding, etc.)

14) The stabilization and removal of pressure from the affected areas of the feet by use and application of accommodative shoe paddings to the interior of the shoes, pair

15) Insole-Extra (e.g., "Spenco", "Ailplast" cork, "Celastex" Kwik-Mold, Styrofoam, Leather, etc.)

16) Splints, Mechanical

17) Mobilization and/or partial immobilization of joint motions in foot and leg, by use of splints attached to shoes and adjusted as indicated for the specific deformity

18) Protective Devices

19) Protective devices for the alleviation or dispersion of pressure, such as from digital deformities, foot deformities, and skin lesions such as ulcers, clavi, hyperkeratoses, etc. Latex bunion

20) Same as above but for a latex hammer-toe shield, single

*Agency Note: Report must accompany billing statement

**Agency Note: With use of local anesthesia

(Source: Added (by codification with no substantive change) at 8 Ill. Reg. 17899)

Section 140.TABLE G Travel Distance Standards

The Department has defined travel distance standards in miles for each county in Illinois. These standards are to be used in the determination of eligibility for payment for the provision of inpatient services to recipients by non-contracting hospitals as stated in Section 140.960.

COUNTY	TRAVEL STANDARD	COUNTY	TRAVEL STANDARD
ADAMS	15	IROQUOUS	30
ALEXANDER	29	JACKSON	22
BOND	28	JASPER	47
BOONE	15	JEFFERSON	19
BROWN	37	JERSEY	19
BUREAU	21	JO DAVIESS	15
CALHOUN	37	JOHNSON	47
CARROLL	25	KANE	15
CASS	28	KANKAKEE	15
CHAMPAIGN	17	KENDALL	20
CHRISTIAN	19	KNOX	15
CLARK	38	LAKE	15
CLAY	37	LASALLE	16
CLINTON	16	LAWARENCE	26
COLES	25	LEE	18
COOK	15	LIVINGSTON	22
CRAWFORD	22	LOGAN	26
CUMBERLAND	30	MCDONOUGH	19
DEKALB	19	MCHENRY	21
DEWITT	21	MACLEAN	15
DOUGLAS	25	MACON	15
DUPAGE	15	MACOUPIN	23
EDGAR	31	MADISON	15
EDWARDS	50	MARION	20
EFFINGHAM	29	MARSHALL	32
FAYETTE	32	MASON	30
FORD	25	MASSAC	19
FRANKLIN	27	MENARD	24
FULTON	18	MERCER	16
GALLATIN	29	MONROE	23
GREEN	22	MONTGOMERY	26
GRUNDY	20	MORGAN	20
HAMILTON	28	MOULTRIE	32

HANCOCK	37	OGLE	28
COUNTY	TRAVEL STANDARD	COUNTY	TRAVEL STANDARD
HARDIN	15	PEORIA	15
HENDERSON	31	PERRY	30
HENRY	15	PIATT	24
PIKE	32	STEPHENSON	15
POPE	34	TAZEWELL	15
PULASKI	30	UNION	48
PUTNAM	16	VERMILION	15
RANDOLPH	20	WABASH	29
RICHARD	25	WARREN	15
ROCK ISLAND	15	WASHINGTON	29
SALINE	22	WAYNE	15
SANGMON	15	WHITE	39
SCHUYLER	35	WHITESIDE	23
SCOTT	30	WILL	15
SHELBY	32	WILLIAMSON	22
ST. CLAIR	15	WINNEBAGO	15
STARK	30	WOODFORD	27

(Source: Added at 9 Ill. Reg. 238, effective December 27, 1985)

Section 140.TABLE H Areas of Major Life Activity

The Individual Is Eligible for ICF/MR Services	The Individual Is Not Eligible for ICF/MR Services
Self Care The ability to perform daily activities to meet basic life needs including feeding, bathing, toileting, dressing, and hygiene and grooming.	
Eligible: The individual feeds (using knife and fork), bathes, and dresses self; combs/brushes hair; may need occasional reminders to initiate activities and follow through on components of tasks or recall performance methods; toilets independently; may shampoo and roll up/set hair; may wash and/or iron and store clothing.	Not Eligible: The individual exercises self care in personal hygiene and grooming, feeding, bathing, dressing, and toileting; may need health care or personal care reminders; may need assistance in selecting or purchasing clothing.
Language Communication involving verbalization or an alternative communication system which enables an individual to convey ideas and information to others (expressive), and understand communication from others (receptive).	
Eligible: The individual can describe or state basic needs or concerns in concrete terms; uses brief concrete phrases and sentences to interact in simple conversation; can answer questions about basic or simple needs or concerns; may use "because" or "but"; is able to express self (verbally or with an alternative system) and be understood by someone who does not know the individual, but does know the communication system; may recognize words or signs; usually cannot provide description or reason for emotions, feelings or personal life events.	Not Eligible: The individual communicates complete verbal concepts and understands them; carries on everyday conversations, but cannot discuss abstract or philosophical concepts; typically can use a telephone; may communicate in writing in simple letter or orders; does not write/communicate about theoretical ideas or important current events.
Learning General cognitive competence; the ability to acquire new behaviors, perceptions and information; and the ability to apply experiences to new situations.	
Eligible: The individual obtains a score in the	Not Eligible: The individual obtains a score in the

moderate to severe/profound range of intellectual functioning as measured by a standardized, full scale, assessment on an individual intelligence test, such as a score of 54 or below on the WAIS-R	mild range of intellectual functioning as measured by a standardized, full scale, assessment on an individual intelligence test, such as a score of 55 or above on the WAIS-R

Mobility

The ability to perform gross- and fine-motor skills. The capability of locomotion, either by independent ambulation or with mobility assistance such as adaptive equipment/mechanical aids.

Eligible:	Not Eligible:
The individual exhibits good body control; can alternate feet to climb stairs; has good gross- and fine-motor skills coordination such as being able to hit a target, throw a ball, run, hop, skip, or jump (these skills are not required for eligibility); may independently transfer into and out of wheelchair; lacks or has limited capacity to perform activities requiring strength or coordination, such as dancing, cursive writing or heavy lifting.	The individual is able to use hands (or adaptive utensils) to care for self; goes about known areas with ease (i.e. local neighborhood, campus or residence) via independent ambulation or adaptive/supportive equipment (wheelchair, walker, cane); may use mass transportation.

Self Direction

The management of, and control over, one's personal and social life, by making decisions which affect and protect one's self interests.

Eligible:	Not Eligible:
The individual may be conscientious about assuming responsibility for simple tasks (household chores, assigned duties); may ask if there is "work" to do; makes an effort to be dependable; attends to a task well (15-20 minutes); may sometimes initiate his/her own activities.	The individual initiates most of his/her own activities; is conscientious about work (duties) and assumes much responsibility; for tasks; requires guidance when activities/jobs necessitate important decision making such as health care, care of others, and complicated occupational activities.

Capacity for Independent Living

The age appropriate ability to live without extraordinary support.

Eligible:	Not Eligible:
The individual can be sent on everyday errands such as to the store, supply or storage area for several items with supervisory oversight; makes minor purchases; may add coins to total a dollar or make change for a dollar; may do simple, routine household	The individual cooks simple meals; performs everyday household tasks (given the opportunity); engages in semiskilled or simple skilled job not requiring complex thinking or judgement; goes to several stores to purchase items; makes change, but may

chores; prepares simple foods that require mixing.	not be able to use banking facilities; may have difficulty handling finances without guidance; goes about local neighborhood or campus of residence with ease and without supervisory oversight; independently recognizes emergency situations and takes action (i.e. stops ongoing activity and exits a building in response to a fire alarm).

(Source: Added at 14 Ill. Reg. 20478, effective December 7, 1990)

Section 140.TABLE I Staff Time and Allocations for Restorative Programs (Recodifed)

(Source: Recodified to 89 Ill. Adm. Code 147.Table B at 12 Ill. Reg. 6956)

Section 140.TABLE J HSA Grouping (Repealed)

(Source: Repealed at 16 Ill. Reg. 19146, effective December 1, 1992)

Section 140.TABLE K Services Qualifying for 10% Add-On (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.TABLE L Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)

(Source: Repealed at 18 Ill. Reg. 18059, effective December 19, 1994)

Section 140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services

a) In accordance with Sections 140.464 and 140.930(a), certain providers who serve women will receive enhanced reimbursement rates for the following services:

Code	Description
W7359	Prenatal risk assessment
59409	Vaginal delivery
59410	Vaginal delivery
52500	C-section delivery
52514	C-section delivery
59515	C-section delivery

b) In accordance with Sections 140.464 and 140.930(a), certain providers who serve children under age 21 will receive enhanced reimbursement rates for the following services:

Code	Description
W7018	Health Kids screening – Chicago/Downstate
W7360	Risk assessment, child referred for mental health assessment/services
W7361	Risk assessment, for mental health services, child, no referral
W7362	Risk assessment, child referred for substance abuse assessment/treatment
W7363	Risk assessment for substance abuse, child, no referral
99201	Office visit – new patient – brief
99202	Office visit – new patient – limited
99203	Office visit – new patient – intermediate
99204	Office visit – new patient – extended
99205	Office visit – new patient – comprehensive
99211	Office visit – established patient – brief
99212	Office visit – established patient – limited
99213	Office visit – established patient – intermediate
99214	Office visit – established patient – extended
99215	Office visit – established patient - comprehensive

c) All other visits and services billed under valid CPT-4 procedure codes will be

reimbursed at January 1, 1993, rates.

(Source: Amended at 20 Ill. Reg. 4345, effective March 4, 1996)