

ILLINOIS REGISTER

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3) 

<u>Section Numbers</u> :	<u>Emergency Action</u> :
140.2	Amendment
140.3	Amendment
140.5	Amendment
140.11	Amendment
140.12	Amendment
140.13	Amendment
140.14	Amendment
140.15	Amendment
140.16	Amendment
140.18	Amendment
140.20	Amendment
140.30	Amendment
140.32	Amendment
140.44	Amendment
140.45	New Section
140.80	Amendment
140.402	Amendment
140.405	New Section
140.413	Amendment
140.414	Amendment
140.417	Amendment
140.420	Amendment
140.425	Amendment
140.428	Amendment
140.440	Amendment
140.441	Amendment
140.442	Amendment
140.443	Amendment
140.445	Amendment
140.449	Amendment
140.457	Amendment
140.458	Amendment
140.469	Amendment
140.470	Amendment
140.471	Amendment

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140.472	Amendment
140.473	Amendment
140.474	Amendment
140.477	Amendment
140.491	Amendment
140.498	Amendment
140.TABLE A	New Section
140.TABLE D	Amendment
140.TABLE F	Repeal

- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and P.A. 97-06899.
- 5) Effective Date: July 1, 2012
- 6) This emergency amendment is to expire beyond the end of the 150-day period, please specify the date on which it is to expire: This emergency rule expires, as authorized by the SMART Act, on June 30, 2013.
- 7) Date Filed with the Index Department: June 29, 2012
- 8) A copy of the emergency amendment, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: Public Act 97-0689, Save Medicaid Access and Resources Together (SMART) Act, gives any agency in charge with implementing a provision or initiative in SMART, the ability to adopt rules through emergency rulemaking in order to provide for the expeditious and timely implementation of SMART. The adoption of this emergency rulemaking is deemed to be necessary for the public interest, safety, and welfare. Pursuant to Public Act 97-0689, the 150-day limitation of the effective period of emergency rules does not apply and the effective period of rules necessary to implement SMART may continue through June 30, 2013. These emergency rules are necessary to implement the provisions and initiatives of SMART.
- 10) Complete Description of the Subjects and Issues Involved: These administrative rules implement changes, improvements, and efficiencies to enhance Medicaid program integrity to prevent client and provider fraud; imposes controls on use of Medicaid services to prevent over-use or waste; expands cost-sharing by clients; and makes rate adjustments and reductions to update rates or reflect budget realities.
- 11) Are there any other rulemakings pending on this Part? Yes

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<u>Section Numbers:</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
140.445	Amendment	May 25, 2012; 36 Ill. Reg. 7757
140.523	Amendment	May 25, 2012; 36Ill. Reg. 7757
140.539	Amendment	May 25 2012; 36 Ill. Reg. 7757
140.570	Amendment	May 25, 2012; 36 Ill. Reg. 7757
140.1001	Amendment	June 1, 2012; 36 Ill. Reg. 8081
140.400	Amendment	June 15, 2012; 36 Ill. Reg. 8594
140.438	Amendment	June 15, 2012; 36 Ill. Reg. 8594

12) Statement of Statewide Policy Objectives: These emergency amendments neither create nor expand any State mandate affecting units of local government.

13) Information and questions regarding this amendment shall be directed to:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/782-1233

The full text of the Emergency Amendments begins on the next page:

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

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
- EMERGENCY
- 140.3 Covered Services Under Medical Assistance Programs
- EMERGENCY
- 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
- EMERGENCY
- 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 Persons Confined or Detained by the Criminal Justice System

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section

- 140.11 Enrollment Conditions for Medical Providers
- EMERGENCY
- 140.12 Participation Requirements for Medical Providers
- EMERGENCY
- 140.13 Definitions
- EMERGENCY
- 140.14 Denial of Application to Participate in the Medical Assistance Program
- EMERGENCY

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NOTICE OF EMERGENCY AMENDMENTS

- 140.15 [Suspension and Denial of Payment, and Recovery of Money and Penalties](#)  
[EMERGENCY](#)
- 140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program  
[EMERGENCY](#)
- 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.18 Effect of Termination, [Suspension, Exclusion](#) or Revocation on Persons Associated with Vendor  
[EMERGENCY](#)
- 140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
- 140.20 Submittal of Claims  
[EMERGENCY](#)
- 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  
[EMERGENCY](#)
- 140.31 Emergency Services Audits
- 140.32 Prohibition on Participation, and Special Permission for Participation  
[EMERGENCY](#)
- 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  
[EMERGENCY](#)
- 140.45 [Withholding of Payments Upon Provider Audit, Quality of Care Review, Credible Allegation of Fraud or Failure to Cooperate](#)  
[EMERGENCY](#)

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NOTICE OF EMERGENCY AMENDMENTS

- 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
- EMERGENCY
- 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)

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- 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

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- 140.400 Payment to Practitioners
- 140.402 Copayments for Noninstitutional Medical Services
- EMERGENCY
- 140.403 Telehealth Services
- 140.405 ~~Non-Institution Rate Reductions~~ ~~Senior Care Pharmaceutical Benefit (Repealed)~~
- EMERGENCY
- 140.410 Physicians' Services
- 140.411 Covered Services By Physicians
- 140.412 Services Not Covered By Physicians
- 140.413 Limitation on Physician Services
- EMERGENCY
- 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers
- EMERGENCY
- 140.416 Optometric Services and Materials
- 140.417 Limitations on Optometric Services
- EMERGENCY
- 140.418 Department of Corrections Laboratory

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- 140.420 Dental Services
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- 140.421 Limitations on Dental Services
- 140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items –  
Dentists (Repealed)
- 140.425 Podiatry Services
- EMERGENCY
- 140.426 Limitations on Podiatry Services
- 140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items – Podiatry  
(Repealed)
- 140.428 Chiropractic Services
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- 140.429 Limitations on Chiropractic Services (Repealed)
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- 140.442 Prior Approval of Prescriptions
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- 140.449 Payment of Pharmacy Items
- EMERGENCY
- 140.450 Record Requirements for Pharmacies
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- 140.452 Mental Health Services



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- 140.454 Types of Mental Health Services
- 140.455 Payment for Mental Health Services
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- 140.458 Prior Approval for Therapy Services
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- 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices
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- 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
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- 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
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- 140.544 Access to Cost Reports (Repealed)
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- 140.555 Minimum Wage
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- 140.566 Out-of-State Placement
- 140.567 Level II Incentive Payments (Repealed)

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- 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

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140.860	County Owned or Operated Nursing Facilities
140.865	Sponsor Qualifications (Repealed)
140.870	Sponsor Responsibilities (Repealed)
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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)
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SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

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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)

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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)
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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)
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SUBPART I: PRIMARY CARE CASE MANAGEMENT PROGRAM

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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

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- 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

SUBPART L: UNAUTHORIZED USE OF MEDICAL ASSISTANCE

Section

- 140.1300 Definitions
- 140.1310 Recovery of Money
- 140.1320 Penalties
- 140.1330 Enforcement

- 140.TABLE A Criteria for the Approval of Non-Emergency Ambulance Transportation Medication Recommended Screening Procedures (Repealed)

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- 140.TABLE B Geographic Areas
- 140.TABLE C Capital Cost Areas
- 140.TABLE D Schedule of Dental Procedures

EMERGENCY

- 140.TABLE E Time Limits for Processing of Prior Approval Requests
- 140.TABLE F Podiatry Service Schedule (Repealed)

EMERGENCY

- 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)

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- 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; preemptory 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; preemptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; preemptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; preemptory 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.



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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,

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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

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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

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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

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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

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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;

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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; amended at 36 Ill. Reg. 2271, effective February 1, 2012; amended at 36 Ill. Reg. 7010, effective April 27, 2012; amended at 36 Ill.7545, effective May 7, 2012; amended at 36 Ill. Reg.\_\_\_\_\_, effective June 11, 2012; emergency amendment at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days.

SUBPART A: GENERAL PROVISIONS

Section 140.2 Medical Assistance Programs

**EMERGENCY**

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- 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);~~
  - ~~34)~~ individuals under age 18 who do not qualify for TANF/TANF-MANG and infants under age one year (see Section 140.7);
  - ~~45)~~ 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);
  - ~~56)~~ persons who are eligible for Title IV-E adoption assistance/foster care assistance from another State and who are living in Illinois;

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- ~~67~~ 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;
- ~~78~~ 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
- ~~89~~ 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



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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.

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- 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: Emergency amended at 36 Ill. Reg.\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.3 Covered Services Under Medical Assistance Programs**

**EMERGENCY**

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- 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; and
  - ~~6) recipients eligible under the State Transitional Assistance Program who are determined by the Department to be disabled; and~~
  - ~~67)~~ 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:

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- 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;

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- 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;

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- 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, pursuant to Section 140.420
- ~~16) Chiropractic services;~~
- ~~1617) Podiatric services, pursuant to Section 140.425 for individuals with a diagnosis of diabetes;~~
- ~~1718) Optical services and supplies; and~~
- ~~1819) Telehealth services pursuant to Section 140.403.~~

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.5 Covered Medical Services Under General Assistance**  
**EMERGENCY**

This program is no longer in effect as of July 1, 2012.

- 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;~~

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- ~~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~~

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- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

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**Section 140.11 Enrollment Conditions for Medical Providers**

**EMERGENCY**

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- 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,

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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.



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- g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a ~~non-emergency transportation~~ vendor is subject to a provisional period and, as defined in Section 140.13, shall be conditional for one year unless limited by the Department, 180 days; During during the period of conditional enrollment, which time the Department may terminate the vendor's eligibility to participate in, or may dis-enroll the vendor from, 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) Unless otherwise specified, such termination~~Termination~~ of eligibility or vendor dis-enrollment, as described in subsection (g) of this Section, and resulting barrments are not subject to the Department's hearing process. However, a dis-enrolled vendor may reapply without penalty.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.12 Participation Requirements for Medical Providers**

**EMERGENCY**

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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;

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- 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.

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- 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

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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.

m) Effective January 1, 2013, a provider, with the exception of a pharmacy provider, that is eligible to participate in the 340B federal Drug Pricing Program under Section 340B of the federal Public Health Services Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under

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Section 340B of the federal Public Health Services Act may exclude Medicaid from their participation in that program. Thus, a provider enrolled in the 340B federal Drug Pricing Program must charge the Department no more than their actual acquisition cost for the drug product. Pharmacy providers are subject to the requirements set forth in Section 140.440(b)(5).

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

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**Section 140.13 Definitions**

**EMERGENCY**

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"Abuse". For purposes of this Part and Part 104, "abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to the Medical Assistance Program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medical Assistance Program. Abuse does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

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"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.

"Credible Allegation". For purposes of this Part, "credible allegation" includes an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

"Credible Evidence". For purposes of this Part, "credible evidence" shall mean evidence that reasonable people would agree as being trustworthy and reliable.

"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.

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

"Fraud". For purposes of this Part and Part 104, "fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

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"Harm". For purposes of this Part and Part 104, "harm" means physical, mental, or monetary damage to recipients or to the Medical Assistance Program.

"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.

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"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.

"Waste". For purposes of this Part and Part 104, "waste" means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the Medical Assistance Program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

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(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

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

- 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 or exclusion 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) ~~The~~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;

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- 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 of any person, firm, corporation, association, agency, institution or other legal entity; if the vendor does not have a necessary license, certificate or authorization.
- 1) immediately, if such vendor is not properly licensed, certified, or authorized;
  - 2) within 30 days of the date when such vendor's professional license, certification or other authorization has been refused renewal, restricted, or has been revoked, suspended, or otherwise terminated; or



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- 3) if such vendor has been convicted of a violation of the Public Aid Code, as provided in Article VIII A of the Code.
- e) The Department may deny the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor if, after reasonable notice and opportunity for a hearing, the Department finds:
  - 1) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership applicant; or a technical or other advisor to an applicant has a debt owed to the Department, and no payment arrangements acceptable to the Department have been made by the applicant.
  - 2) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; and owner of a sole proprietorship applicant; a partner in a partnership vendor applicant; or a technical or other advisor to an applicant was: (i) a person with management responsibility, (ii) an officer or member of the board of directors of an applicant, (iii) an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of sole proprietorship, (v) a partner in a partnership vendor, (vi) a technical or other advisor to a vendor; during a period of time where the conduct of that vendor resulted in a debt owed to the Department, and no payment arrangements acceptable to the Department have been made by that vendor.
  - 3) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant from a current or prior vendor who has a debt owed to the Department, no payment arrangements acceptable to the Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.
  - 4) There is a credible allegation of a transfer of management responsibilities, or direct or indirect ownership, to an applicant from a current or prior vendor who has debt owed to the Department, and no payment

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arrangements acceptable to the Department have been made by the vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

- 5) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant who is a spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, relative by marriage, nephew, cousin, or relative of a current or prior vendor who has a debt owed to the Department and no payment arrangements acceptable to the Department have been made.
- 6) There is a credible allegation that the applicant's previous affiliations with a provider of medical services that has an uncollected debt, a provider that has been or is subject to a payment suspension under a federal health care program, or a provider that has been previously excluded from participation in the Medical Assistance Program, poses a risk of fraud, waste, or abuse to the Department.

As used in this Section, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.15 Suspension and Denial of Payment, and Recovery of Money and Penalties**  
**EMERGENCY**

- a) The Department may suspend or deny payment, in whole or in part, to a vendor or the vendor's alternate payee if such payment would be improper or erroneous or would otherwise result in overpayment. The Department may recover money improperly or erroneously paid, or overpayments (see subsection (b) of this Section for exception to recovery of money), made to a vendor or vendor's alternate payee, either by setoff (deducting from Department obligations to the vendor or the designated alternate payee), deductions from future billings or by requiring direct repayment. Payments may be suspended, denied or recovered from a vendor or alternate payee:

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- 1) for services rendered in violation of the Department's provider notices, statutes, rules, and regulations;
  - 2) for services rendered in violation of the terms and conditions prescribed by the Department in its vendor agreement;
  - 3) for any vendor who fails to grant the Office of Inspector General timely access to full and complete records, including, but not limited to, records relating to recipients under the Medical Assistance Program for the most recent six years, in accordance with 89 Ill. Adm. Code 140.28, and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General; provided, however, that this subsection does not require vendors to make available the medical records of patients for whom services are not reimbursed under this Code or to provide access to medical records more than six years old;
  - 4) when 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;
  - 5) when the vendor previously rendered services while terminated, suspended, or excluded from participation in the Medical Assistance Program or while terminated or excluded from participation in another state or federal medical assistance or health care program; or
  - 6) for ground ambulance services rendered services as the result of improper or false certification. Such overpayments can be recovered from a vendor, including, but not limited to, from the discharging physician, the discharging facility, and the ground ambulance service provider.
- 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.

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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 ~~an~~ the overpayment resulted from ~~at~~ the vendor or the designated alternate payee ~~knowingly-willfully~~ making, using or causing to be made or used, a false record or statement to obtain payment or other benefit from or misrepresentation of a material fact in connection with billings and payments under the medical assistance program, in addition to any other penalties that may be prescribed by law:-

- 1) the Department may recover interest on the amount of the overpayment or other benefit from the vendor or alternate payee at the rate of five percent annum;
- 2) such vendor or alternate payee shall be subject to civil penalties consisting of an amount not to exceed three times the amount of payment or other benefit resulting from each such false record or statement; and
- 3) such vendor or alternate payee shall be subject to the sum of \$2,000 for each such false record or statement for payment or other benefit.

For purposes of this Section, "knowingly""willfully" means that a vendor or alternate payee with respect to information: (i) has the information, (ii) acts in deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.~~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.~~

e) If a vendor has the same taxpayer identification number (assigned under Section 6109 of the Internal Revenue Code of 1986) as is assigned to a vendor with past-due financial obligations to the Department, the Department may make any necessary adjustments to payments to that vendor in order to satisfy any past-due obligations, regardless of whether the vendor is assigned a different billing number under the Medical Assistance Program.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

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

**EMERGENCY**

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- 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, or exclude a person or entity from participation in the Medical Assistance Program, 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, person or entity is not properly licensed, certified, authorized or otherwise qualified, or the vendor, ~~person or entity's~~ professional license, certificate or other authorization has not been renewed or has been restricted, revoked, suspended or otherwise terminated as determined by the appropriate licensing, certifying or authorizing agency. Such termination, suspension or exclusion shall be immediately effective;
  - 3) The vendor violates records requirements as set forth in Department laws, regulations, rules, provider handbooks and policies:-
    - A) The vendor has failed to keep or timely 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 and completely disclose the extent of the services or supplies provided; or
      - ii) full and complete records required to be maintained by the Department regarding payments claimed for providing services.

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- 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 ~~an individual 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

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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, suspended, terminated, or barred from participation in the Medical Assistance Program, or in another state or federal medical assistance or health care program;

9) The vendor has a delinquent debt owed to the Department;

109) 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 or limited liability company 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)(109), "applicable Federal or State law or regulation" ~~shall include, but is not limited to include~~ licensing or certification standards contained in State or Federal law or regulations related to the Medical Assistance Program, any

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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)(109), 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;

~~11+0~~) 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 ~~offensefelony~~ not related to the Medical Assistance Program, if the ~~offensefelony~~ constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;

~~12+4~~) 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:

- A) ~~of murder; or~~
- B) a Class X felony under the Illinois Criminal Code of 1961;
- C) sexual misconduct that may subject recipients to an undue risk of harm;
- D) a criminal offense that may subject recipients to an undue risk of harm;
- E) a crime of fraud or dishonesty;
- F) a crime involving a controlled substance;

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G) a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility; or

H) other financial misconduct related to a health care program.

1342) 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.

c) The Department may terminate, suspend, or exclude vendors who pose a risk of fraud, waste, abuse, or harm, as defined in 89 Ill. Adm. Code 140.13, from participation in the Medical Assistance Program.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons Associated with Vendor**

**EMERGENCY**

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a) Upon termination, suspension or exclusion 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, suspension or exclusion is barred from participation in the Medical Assistance Program.

b) Upon termination, suspension or exclusion of a corporate vendor, the officers and persons owning, directly or indirectly, 5% or more of the shares of stock or other

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evidences of ownership in the vendor during the time of any conduct that served as the basis for that vendor's termination, suspension or exclusion are barred from participation in the Medical Assistance Program.

- c) Upon termination, suspension or exclusion 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, suspension or exclusion 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.

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(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

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**Section 140.20 Submittal of Claims**

**EMERGENCY**

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- 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

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- 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, that can be processed without obtaining additional information from the provider of the service or from a third party, must be received by the Department, or its fiscal intermediary, no later than ~~180 days~~<sup>12 months</sup> 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.~~

- 1) 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.
- 2) In the case of a provider whose enrollment is in process by the Department, the 180-day period shall not begin until the date on the written notice from the Department that the provider enrollment is complete.

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- 3) In the case of errors attributable to the Department or any of its claims processing intermediaries which result in an inability to receive, process, or adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.
- 4) In the case of a provider for whom the Department initiates the monthly billing process.
- 5) For claims for rendered during a period for which a recipient received retroactive eligibility, claims must be filed within 180 days after the Department determines the applicant is eligible.
- 6) For claims for which the Department is not the primary payer, claims must be submitted to the Department within 180 days after the final adjudication by the primary payer.
- 7) In the case of long term care facilities, admission documents shall be submitted within 30 days of an admission to the facility through the Medical Electronic Data Interchange (MED) or the Recipient Eligibility Verification (REV) System, or shall be submitted directly to the Department of Human Services using required admission forms. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.
- 8) For hospital inpatient claims, the 180 days is measured from the date of discharge.

- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.30 Audits**

**EMERGENCY**

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- a) Whether pre-payment or post-payment, all AH 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: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.32 Prohibition on Participation, and Special Permission for Participation**  
**EMERGENCY**

- 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;

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- 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) A person who owns, directly or indirectly 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor who owes a debt to the Department, if that vendor has not made payment arrangements acceptable to the Department, shall not

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transfer his or her ownership interest in that vendor, or vendor assets of any kind, to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

~~43~~) 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.

~~54~~) 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;

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- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)



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**Section 140.44 Withholding of Payments Due to Fraud or Misrepresentation**

**EMERGENCY**

- a) Payments on pending and subsequently submitted bills may be withheld, in whole or in part, to a provider or alternate payee, ~~where there is credible~~ ~~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:

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- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.45 Withholding of Payments Upon Provider Audit, Quality of Care Review, Credible Allegation of Fraud or Failure to Cooperate**  
**EMERGENCY**

- a) The Department may withhold payments, in whole or in part, to a provider or alternate payee upon:
  - 1) initiation of an audit

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- 2) quality of care review
  - 3) investigation when there is a credible allegation of fraud; or
  - 4) the provider or alternate payee is demonstrating a clear failure to cooperate with the Department such that circumstances give rise to the need for a withholding of payments.
- b) The Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments.
- c) A provider or alternate payee may request a hearing or a reconsideration of payment withholding, and the Department must grant such a request.
- d) The Department must send notice of its withholding of payments within five days of taking such action. The notice shall:
- 1) Set forth the general allegation as to the nature of the withholding action; however, the notice need not disclose any specific information concerning its ongoing investigation.
  - 2) State that payments are being withheld in accordance with 305 ILCS 5/12-4.25(K-5).
  - 3) State that the withholding is for a temporary period, as specified in subsection (g) of this Section, and cite the circumstances under which withholding will be terminated.
  - 4) Specify, when appropriate, which type or types of claims are withheld.
  - 5) Inform the provider or alternate payee of the right to request a hearing or a reconsideration of the withholding by the Department, including the ability to submit written evidence.
  - 6) Inform the provider or alternate payee that a written request may be made to the Department for a hearing or reconsideration for the full or partial release of withheld payments and that such requests may be made at any time after the Department first withholds such payments.

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- e) A provider or alternate payee may request for reconsideration of payment withholding for the purpose of a full or partial release of payments withheld pursuant to 305 ILCS 5/12-4.25(K-5). The provider or alternate payee shall submit a written request for reconsideration and the reasons therefore to the Inspector General at:

Office of Inspector General  
404 North Fifth Street  
Springfield, Illinois 62706

Or by e-mail to: [oigwebmaster@illinois.gov](mailto:oigwebmaster@illinois.gov).

- 1) The request may include documentation to contest a credible allegation of fraud or failure to cooperate with the Department.
- 2) 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 medical assistance program recipients. Factors in this decision may include, but are not limited to, recipients access to medical services or the potential transport of patients from long term care settings.

- f) A provider or alternate payee may request a hearing on the issue of a withholding of payments pursuant to 305 ILCS 5/12-4.25(K-5). The only issues at hearing will be whether a partial or full release of funds is proper based on the following factors:

- 1) Whether there is a credible allegation of fraud;
- 2) Whether the provider or alternate payee demonstrated a clear failure to cooperate with the Department such that the circumstances give rise to the need for a withholding of payments;
- 3) Whether a release is in the best interest of the recipients of medical assistance based on access to medical services for recipients; and
- 4) The potential movement of patients from long term care settings.

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

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- 1) The Department determines that there is insufficient evidence of fraud, or the provider or alternate payee demonstrates clear cooperation with the Department, as determined by the Department, such that the circumstances do not give rise to the need for withholding of payments; or
- 2) the withholding of payments has lasted for a period in excess of three years.

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(Source: Emergency Added at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.80 Hospital Provider Fund**

**EMERGENCY**

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- 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.

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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, AND 5A-15 of the Public Aid Code, for State fiscal years 2009 through 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to

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\$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 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, 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 14<sup>th</sup> 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 14<sup>th</sup> 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.

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- 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



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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 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, 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.

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- 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

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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

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Department as described in subsection (c) of this Section. The request must be received by the Department prior to the due date of the assessment.

- 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.

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- 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 ensure that a delay of payment request, as defined under subsection (h)(3)(A) of this Section, is received by the Department prior to the payment due date, 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;

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- 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 ensure their request is received by the Department prior to the payment due date, 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:

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- 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

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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



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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.

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- 3) For State fiscal years 2004 through 2014 and the portion of State fiscal year 2015 that ends December 31, 2014, 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.

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- 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.

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- 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).

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- 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 by emergency at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

**Section 140.402 Copayments for Noninstitutional Medical Services**

**EMERGENCY**

- a) Effective July 1, ~~2012~~<sup>2003</sup>, each recipient, with the exception of those classes of recipients identified in subsection (d) of this Section, may be required to pay a copayment of \$2.00 for generic legend drugs, including over-the-counter drugs billed to the Department, and for other services, the nominal copayment amount as defined in federal regulations at 42 CFR 447.54, which for federal fiscal year 2012 is \$3.65 for 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 or an Advance Practice Nurse billed to the Department, but excluding psychiatric (CPT codes 90801 through 90899) services, with the exception of those office visits for services identified in subsection (e) of this Section, may require a copayment of \$2.00.

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- 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.~~
  - 3) Each medical encounter billed to the Department by an Encounter Rate Clinic (ERC), Federally Qualified Health Center (FOHC) or Rural Health Clinic (RHC), but excluding behavioral services provided by those facilities.
- 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).

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- 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.~~
  - ~~67) Emergency services as defined at 42 CFR 447.53(b)(4).~~
  - ~~78) Any pharmacy compounded drugs.~~
  - ~~89) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.~~
  - ~~910) Family planning services.~~
  - ~~1011) Other therapeutic drug classes as specified by the Department.~~

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.405 ~~Non-Institutional Rate Reductions~~ ~~Senior Care Pharmaceutical Benefit~~ (Repealed)**

**EMERGENCY**

Notwithstanding any provisions to the contrary in this Part, effective for dates of service on or after July 1, 2012, reimbursement rates and other payments to non-institutional providers shall be reduced by an additional 2.7% from the rates or payments that were otherwise in effect on June 30, 2012, except that such reductions shall not apply to:

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a) Rates or payments for physician services, dental services, services reimbursed through an encounter rate, services provided under the Medicaid Rehabilitation Option of the Illinois Title XIX State Plan.

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b) Rates or payments, or the portion thereof, paid to a provider that is operated by a unit of local government or State University that provides the non-federal share of such services.

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c) Pharmacy services, which are reduced pursuant to Sections 140.414 and 140.445

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(Source: Emergency added at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.413 Limitation on Physician Services**

**EMERGENCY**

- 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



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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 – ~~Covered only with prior approval by the Department.~~ 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.~~

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- 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 [Practitioners Rendering Medical Services](#)~~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

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- vii) the group session is provided in accordance with a clear written description of goals, methods and referral criteria; and
  - viii) ~~Group psychotherapy is not covered for recipients who are residents in a facility licensed under the Nursing Home Care Act [210 ILCS 45] or the Specialized Mental Health Rehabilitation Act [210 ILCS 48]. 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

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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 12<sup>th</sup> 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

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- 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

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- D) 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:

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- 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.

14) Coronary artery by-pass grafts – Covered only with prior approval by the Department.

- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers**

**EMERGENCY**

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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

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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 Identifier (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) Effective ~~July 1, 2012~~February 1, 2012, the Department shall pay for covered outpatient drug items dispensed or administered by a non-pharmacy provider at a rate equal to the lowest of the provider's usual and customary charge to the public; or
    - A) The Average Sales Price (ASP) plus 6 percent. ASP means the ASP as defined in the Social Security Act, Title XVIII, section 1847A(c) (42 USC 1395 w-3a(c)) and calculated by the federal Centers for Medicare and Medicaid Services (CMMS); or
    - B) The State upper limit.



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~~3B)~~ In cases in which ASP is not available and no State upper limit has been developed, the Department's lowest maximum allowable price for all covered NDCs assigned to the HCPCS billing code (the methodology for determining the Department's maximum prescription prices is specified in Section 140.445(b)(1) and (b)(2)).

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~~43)~~ Reimbursement rates for drugs dispensed or administered by non-pharmacy providers shall be updated no less frequently than twice per calendar year.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.417 Limitations on Optometric Services**

**EMERGENCY**

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:
  - 1) The power is at least 0.75 diopters in either the sphere or cylinder component; or
  - 2) The difference between the old and new prescription is at least 0.75 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.

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- d) Payment shall be made for one pair of eyeglasses or set of lenses for adults in a 24-month period. Payment shall be made for more than one pair of eyeglasses or set of lenses per year for children through age 20 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.
- 1) Contact lenses and related contact lens services;
  - ~~2) A third pair of eyeglasses in one year for adults 21 years of age or older;~~
  - ~~23)~~ Custom made artificial eyes;
  - ~~34)~~ Low vision devices; and
  - ~~45)~~ Any item or service not specifically included in the schedule of procedures for optical services and supplies.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.420 Dental Services**  
**EMERGENCY**

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- 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" as~~ specified in subsections (c) and (d) of this Section, payment shall be made for covered dental services as described in (b)(1) and (b)(2) of this Section and as listed in 140. Table D 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~~ payment shall not be made for experimental dental care and procedures performed only for cosmetic reasons, 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 21 years and older;~~

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- ~~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(e));~~
  - ~~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.~~
- d) Effective for dates of service on or after July 1, 2012, notwithstanding other provisions of this Section or Section 140.421, dental services age 21 years and older shall be limited to those dental services that are medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction and dental services that are medically necessary as a prerequisite for necessary medical care.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012 for a maximum of 365 days)

**Section 140.425 Podiatry Services**

**EMERGENCY**

- a) Payment for podiatry services shall be made only to licensed podiatrists.
- b) Payment shall be made for those podiatric services provided to recipients under the age of 21 or recipients age 21 and over who have been diagnosed with diabetes as defined in the International Classification of Diseases. The allowable diagnoses code ranges will be specified in the Handbook for Providers of Podiatric Services. ~~that are:~~

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c) Payment shall be made for those podiatric services that are:

- 1) Limited to recipients under the age of 21 or recipients age 21 and over who have been diagnosed with diabetes as defined in the International Classification of Diseases.
- 2) Essential for the diagnosis and treatment of conditions of the feet.
- 3) 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.
- 4) Performed by the podiatrist or under the direct supervision of the podiatrist.
- 5) 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.~~

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d) 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,

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- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.428 Chiropractic Services**

**EMERGENCY**

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- a) Payment shall be made only to chiropractors.
- b)** Payment shall only be made for chiropractic services provided to recipients under the age of 21.
- cb)** 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: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.440 Pharmacy Services**

**EMERGENCY**

- 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.

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- 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).
- 4) Effective August 1, 2012, in order to dispense blood factor, a pharmacy must sign a standards of care agreement with the Department.
- 5) Effective October 1, 2012, a pharmacy provider that is eligible to participate in the 340B federal Drug Pricing Program under Section 340B of the federal Public Health Services Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under Section 340B of the federal Public Health Services Act may exclude Medicaid from their participation in that program. A provider enrolled in the 340B federal Drug Pricing Program must charge the Department no more than their actual acquisition cost for the drug product plus the Department established dispensing fee, defined at 140.445(b), except in the case of blood factor. A 340B pharmacy may charge the Department actual shipping costs in addition to their acquisition cost and dispensing fee.
- 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.

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- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.441 Pharmacy Services Not Covered**

**EMERGENCY**



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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.

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- k) Blood factor when a patient has not had a comprehensive examination at a federally-funded Hemophilia Treatment Center (HTC) during the 365 days preceding the date of service.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.442 Prior Approval of Prescriptions**

**EMERGENCY**

- 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.

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- 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.

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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;~~

~~AB) Contraceptive drugs and products; and~~

~~C) Oncolytic drugs; and~~

~~BD) 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.

~~e) 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~~

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~~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.~~

~~c~~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.

~~d~~e) In accordance with subsection ~~(d)(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 ~~(d)(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; and

C) Anti-Rejection Drugs;

~~D) Antipsychotics;~~

~~E) Anticonvulsants;~~

~~F) Insulin; and~~

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~~G) Anti-Hemophilic Factor Concentrates.~~

2) Brand name prescription drugs are exempt from the prior approval requirements of subsection ~~(d)~~~~(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.

e) The Department may require prior approval prior to reimbursement for a prescription drug if the patient for whom the drug is prescribed has already received four prescription drugs in the preceding 30-day period. For purposes of subsection (d) of this Section, prescription drugs in the following therapeutic classes shall not count towards the limit of four prescription drugs and shall not be subject to prior approval requirements because a patient has received four prescription drugs in the preceding 30 days:

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- 1) Antiretrovirals;
- 2) Antineoplastics;
- 3) Anti-Rejection Drugs; and
- 4) Antibiotics.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.443 Filling of Prescriptions**

**EMERGENCY**

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- 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 Identifier (NPI); or

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- 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.

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- 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.
- h) [Effective January 1, 2013, brand-name, solid, oral drugs dispensed to clients residing in any facility that provides medical group care services as defined in Section 140.500, must be dispensed in 14-day supplies. Exceptions: Solid oral doses of antibiotics and drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are](#)



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customarily dispensed in their original packaging to assist patients with compliance (for example, oral contraceptives), may be dispensed in days' supplies greater than 14 days.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.445 Legend Prescription Items (Not Compounded)**

**EMERGENCY**

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Effective ~~July 1~~~~February 1~~, 2012, for legend (prescription) drugs, the Department shall pay the lower of:

- a) the pharmacy's usual and customary charge to the general public; or
- b) the Department's maximum price plus the established dispensing fee of ~~\$5.35~~~~\$6.35~~ for generic drugs and ~~\$2.40~~~~\$3.40~~ for brand name drugs. The Department shall pay only one dispensing fee per 30 days' supply for those drugs dispensed in accordance with Section 140.443(h). If the generic dispensing rate during the quarter ending June 30, 2014 is not 2% higher than the generic dispensing rate during the quarter ending December 31, 2011, then effective January 1, 2015, the dispensing fee shall be \$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) Wholesale Acquisition Cost (WAC); or Suggested Wholesale Price (SWP) minus 25%; or
    - B) the Federal upper limit as established under section 1927(e)(4) of the Social Security Act (42 USC 1396r-8(e)(4)); or
    - C) the State upper limit.
  - 2) For brand name drugs, the Department's maximum price is calculated as the lowest of:
    - A) WAC ~~plus 1%~~; or

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B) the State upper limit.

3) These rates supercede any rates in effect as a result of any rulemaking filed prior to the effective date of this emergency rulemaking.

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(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.449 Payment of Pharmacy Items**

**EMERGENCY**

- 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

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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

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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

Glucostrix Strips

Hema-Combistix

Hemastix Strips

Hematest Tablet

Keto-Diastix

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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: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for maximum of 365 days)

**Section 140.457 Therapy Services**

**EMERGENCY**

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 with a maximum of 20 visits allowed per discipline per State fiscal year for adults age 21 and over. Payment may be made for therapy services provided by:

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- 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: Emergency added at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.458 Prior Approval for Therapy Services**

**EMERGENCY**

- 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) ~~the individual is under the age of 21, 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 ~~judgment~~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.

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(Source: Emergency amendment at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.469 Hospice**

**EMERGENCY**

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- 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.

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- 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



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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.

h) Effective with dates of service on and after July 1, 2012, the following services will not be covered outside of the hospice program benefit for patients electing hospice care. These services will not be paid separately:

- 1) Dental services.
- 2) Optometric services and eyewear.
- 3) Nursing services provided by registered nurses and licensed practical nurses.
- 4) Physical therapy services.
- 5) Occupational therapy services.
- 6) Speech therapy services.
- 7) Audiology services.
- 8) General clinic services.
- 9) Psychiatric clinic Type A services.
- 10) Psychiatric clinic Type B services.
- 11) Hospital outpatient physical rehabilitation.
- 12) Healthy kid services
- 13) Early intervention services.
- 14) Mental health rehabilitation option.

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- 15) Alcohol and substance abuse rehabilitation services.
- 16) Medical equipment.
- 17) Medical supplies.
- 18) Medicar transportation.
- 19) Taxicab transportation.
- 20) Service car transportation.
- 21) Private auto transportation.
- 22) Other transportation.
- 23) Social work services.
- 24) Psychological services.
- 25) Home health services.
- 26) Homemaker services, and
- 27) Palliative drugs.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.470 Eligible Home Health Care, Nursing and Public Health Providers**  
**EMERGENCY**

The Department will reimburse the following as home health care providers:

- a) The following classes of providers may enroll with the Department as home health care providers:
  - 1) A Medicare-certified home health agency licensed by the Department of Public Health;

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- 2) ~~A home nursing agency licensed by the Department of Public Health;~~
- b) ~~A home health agency certified by the Department of Public Health as Medicare certifiable or as meeting the requirements of Medicare;~~
- e) 3) A self-employed nurse ~~who is~~ licensed by the Department of Financial and Professional Regulations 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; or
- e) 4) 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.~~
- b) Home health care providers must implement an auditable electronic service verification.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.471 Description of Home Health Care Services**  
**EMERGENCY**

- 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, a specialized mental health rehabilitation facility or a supportive living facility. The term “residence” includes an intermediate care facility for the mentally retarded only to the extent

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that home health services are not required to be provided under 89 Ill. Adm. Code 144.

- d) To be eligible for reimbursement by the Department, initial certification of intermittent skilled nursing services or therapy services must have documentation that a face-to-face encounter was conducted by the practitioner requesting services. The following conditions must be met for the face-to-face encounter.
- 1) The physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter, and including an explanation of why the clinical findings of such encounter support that the patient is in need of either intermittent skilled nursing services or therapy services as defined in Section 140.472.
- 2) The face-to-face encounter must be performed by the certifying physician him or herself, by a nurse practitioner, a clinical nurse specialist who is working in collaboration with the physician in accordance with State law, a certified nurse midwife as authorized by State law, a physician assistant under the supervision of the physician, or for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility. The documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated and signed by the certifying physician.
- A) If the certifying physician does not perform the face-to-face encounter him or herself, the nonphysician practitioner or the physician who cared for the patient in an acute or post-acute facility performing the face-to-face encounter must communicate the clinical findings of that face-to-face patient encounter to such certifying physician.
- B) If a face-to-face patient encounter occurred within 90 days of the start of care but is not related to the primary reason the patient requires home health services, or the patient has not seen the certifying physician or allowed nonphysician practitioner within

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the 90 days prior to the start of the home health episode, the certifying physician or nonphysician practitioner must have a face-to-face encounter with the patient within 30 days of the start of the home health care.

C) The face-to-face patient encounter may occur through telehealth, in compliance with Section 140.403.

D) The physician responsible for certifying the patient for home care must document the face-to-face encounter on the certification itself, or as an addendum to the certification (as described in (a)(1) of this Section) that the condition for which the patient was being treated in the face-to-face patient encounter is related to the primary reason the patient requires home health services, and why the clinical findings of such encounter support that the patient is in need of either intermittent skilled nursing services or therapy services as defined in Section 140.472. The documentation must be clearly titled, dated and signed by the certifying physician.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.472 Types of Home Health Care Services**

**EMERGENCY**

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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.~~Health Aid.
- d) ~~Speech~~-Therapy services: Speech, occupational and physical therapy services are limited to a maximum of 20 visits per State fiscal year for participants who are age 21 and over. These services require prior approval by the Department.

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e) ~~Occupational Therapy.~~

f) ~~Physical Therapy.~~

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012 for a maximum of 365 days)

**Section 140.473 Prior Approval for Home Health Care Services**

**EMERGENCY**

- 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 intermittent skilled nursing services provided by a home health agency provider for participants within 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 who are 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.

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(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012 for a maximum of 365 days)

**Section 140.474 Payment for Home Health Care Services**  
**EMERGENCY**

- a) Except for services described in subsections (b) ~~and (e)~~ of this Section, home health agencies shall be paid an all inclusive, per visit rate which shall be the lowest of the:
- 1) ~~Agency's~~ the agency's usual and customary charge for the service;
  - 2) ~~Agency's~~ the agency's Medicare rate; or
  - 3) ~~the~~ Department's maximum allowable rate of as identified in the Home Health Fee Schedule, \$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) ~~Self-employed~~ 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.~~
- 1) Payment shall be at the community rate for such services, as determined by the Department for each case, at the time prior approval is given.
  - 2) ~~Payment for In-home~~ in-home shift nursing for children who are under 21 years of age under Section 140.472(b) shall be at the Department's established hourly rate to an agency licensed to provide these services. The hourly rate for in-home shift nursing care may be adjusted in consideration of the appropriation of funds by the General Assembly.

(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices**  
**EMERGENCY**

- a) Prior approval for the purchase, repair or rental of certain medical equipment, prosthetic devices and orthotic devices is required except when:

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- 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~~
- ~~23) 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: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.491 Limitations on Medical Transportation**

**EMERGENCY**

- 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. This subsection applies to all transportation, including exceptions set forth in subsection (b) of this Section.
- 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.

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- 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.~~
- 23) 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) Requirements for non emergency ambulance services, criteria for the approval of non emergency ambulance services, physician certification and orders.
- 1) Whenever a patient covered by a medical assistance program under this Part or by another medical program administered by the Department is being discharged from a facility, a physician discharge order, as described in this Section shall be required for each patient whose discharge requires medically supervised ground ambulance services. Facilities shall develop procedures for a physician with medical staff privileges to provide a written and signed physician discharge order.
  - 2) The physician discharge order shall specify the level of ground ambulance services needed and complete a medical certification establishing the criteria for approval of non-emergency ambulance transportation, as published by the Department of Healthcare and Family Services that is met by the patient. This order and the medical certification shall be completed prior to ordering a non emergency ambulance transportation service and prior to patient discharge.
  - 3) In the event a physician is unable to complete the medical certification, he may designate another medical licensed healthcare provider, authorized to

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prescribe on behalf of the physician, to complete the medical certification. The physician remains responsible for the accuracy of the medical certification and appropriate determination that the transport meets the requirements for the Department's criteria for non-emergency ambulance transports. However, the physician remains responsible for the accuracy of the medical certification and appropriate determination that the transport meets the requirements for the Department's criteria for non-emergency ambulance transports.

4) To be eligible for non-emergent ambulance transportation, the service must meet the Department's criteria, as set forth in 140.Table A.

de) 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.

ed) The Department shall refuse to accept requests for ~~non-emergency transportation~~ authorizations, from specific vendors who pose a risk of fraud, waste, abuse or harm, as defined in 89 Ill. Adm. Code 140.13, 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, suspension or exclusion 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:

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- 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.

| **fe)** 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.

| **gf)** 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.

| **hg)** 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:

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- 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: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140.498 Fingerprint-Based Criminal Background Checks**

**EMERGENCY**

a) ~~Non-Emergency Transportation~~

a) ~~Vendors who pose a risk of fraud, waste, abuse or harm~~ ~~Non-emergency transportation vendors~~, as defined in ~~89 Ill. Adm. Code Section~~ 140.13, and applicants ~~of the Medical Assistance Program~~ 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.

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b) ~~2)~~The following individuals shall be subject to the fingerprint-based background check described in subsection (a) of this Section:

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1)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.

2)B) In the case of a vendor that is a partnership, every partner.

3)C) In the case of a vendor that is a sole proprietorship, the sole proprietor.

4)D) Each officer and each individual with management responsibility of the vendor.

c)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.

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d)4) Within 30 days after any individual identified in subsection (b)(a)(2) of this Section acquiring an ownership interest, pursuant to subsection (b)(1), (b)(2) or (b)(3)(a)(2)(A), (B) or (C) of this Section, or assuming management responsibility, pursuant to subsection (b)(4)(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.

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e) ~~5)~~The failure of any individual identified in subsection (b)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 (d)(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.

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f) ~~6)~~This Section does not apply to:

1)A) Vendors owned or operated by government agencies; and

2)B) Private automobiles.

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(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

**Section 140. TABLE A Criteria for the Approval of Non-Emergency Ambulance Transportation ~~Medicheck Recommended Screening Procedures (Repealed)~~**

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**EMERGENCY**

a) Non-emergency ambulance transportation means: transportation of a patient whose medical condition requires transfer by stretcher and ongoing clinical observation to the nearest available appropriate provider. This transportation is provided in a ground ambulance vehicle and includes medically necessary supplies and services, plus the provision of basic life support (BLS) services or advanced life support (ALS) services, as defined by the rules and regulations of the Illinois Department of Healthcare and Family Services (Department) and the Illinois Department of Public Health (DPH).

To be eligible for non-emergent ambulance transportation, the service must meet the following criteria:

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1) The patient has a physician order for a documented diagnosis, condition or symptoms that require non-emergent clinical observation or treatment at the time of the transport, continuing through the transport, and is expected to require the same clinical observation or treatment at the designation.

2) Both the patient's diagnosis, and the physician order for non-emergent ambulance transportation with clinical observation, are documented in each of the following:

A) the discharging provider or facility's pre-transfer patient treatment record;

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B) the ambulance patient care record; and

C) a medical certification form as designated by the Department.

3) Any other means of transportation (i.e., taxi, wheelchair van, or private automobile) is contraindicated by the attesting physician that completes the medical certification form described in (2)(C) of this Table.

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4) The sole purpose of the transport is NOT for the navigation of stairs and/or the assisting or lifting of a patient at a medical facility or appointment.

b) In addition to adherence to the criteria in subsection (a) of this Table, at least one of the following criteria must be met. Non-emergent ambulance transportation service must be documented in compliance with one of the following criteria. Non-emergent ambulance transportation service will only be approved in cases where clinical observation is medically necessary at the transferring facility and is medically necessary at the destination. Please note that examples are provided for guidance, but are not intended to be an all inclusive or an all exclusive list:

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1) Isolation Precautions. A patient who has a diagnosed or suspected communicable disease or hazardous material exposure, who must be isolated from the public or whose medical condition must be protected from public exposure, and for whom there is a physician's order for isolation precautions.

Example – Inclusion: This criterion includes a patient who has a condition of methicillin-resistant Staphylococcus aureus (MRSA) infection, who is currently undergoing treatment for the infectious condition and who continues to have symptoms, such as cough, drainage, or fever.

Example – Inclusion: A patient with a dangerous communicable disease that has the potential to cause an epidemic or threaten serious illness or death to others if not controlled.

Example – Inclusion: This includes a patient where “contact Isolation” is ordered for Clostridium difficile diarrhea, often called C. difficile.

Example – Exclusion: This criterion does not include a patient who has a history of MRSA or C. difficile, or has been treated for MRSA or C. difficile and is no longer symptomatic.

Example – Exclusion: This criterion does not include a patient with surgical drainage complications for which wound care precautions are ordered, unless the patient's surgical complication includes a draining wound that saturates a dressing and requires that the patient must be isolated from the public.

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Example – Exclusion: This criterion does not include a patient who has a surgical dressing, ostomy, G-tube, or other dressing, that is dry and intact.

Example – Exclusion: This criterion does not include a patient who has a physician order for wound care precautions alone without a physician order for isolation precautions.

Example – Exclusion: This criterion does not include a patient who is incontinent and who requires the use of adult diapers.

- 2) A patient with a transfer order requiring the administration of supplemental oxygen by a third party assistant/attendant or requiring the regulation or adjustment of oxygen prior to and continuing through transport, and who is expected to require supplemental oxygen at the destination.

Example – Inclusion: This includes a patient where there is a reasonable medical expectation that flow rate will need to be adjusted, and requires pulse oximetry to guide administered flow rate with a prior physician order indicating the threshold level at which the oxygen saturation should be maintained at or above.

Example – Inclusion: This includes a patient who has a physician order that specifies oxygen to be administered by mask, nasal cannula, collar over tracheostomy, at a specific flow rate liters per minute.

Example – Inclusion: A patient who has supplemental oxygen that is required and is administered prior to transport and for the duration of transport. Included in this group are patients who require third party assistance to administer, regulate or adjust oxygen during transport.

Example – Exclusion: This criterion does not include patients who are capable of self-administration of portable or home oxygen or who have an available trained caregiver to administer the oxygen.

- 3) A patient with a transfer order for advanced continuous airway management prior to, during, and after transport by means of an artificial airway through tracheal intubation (nasotracheal tube, orotracheal tube, or tracheostomy tube).

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Example – Inclusion: A patient who is quadriplegic that requires advanced airway management including mechanical ventilation during transport.

Example- Inclusion: A patient that requires continuous airway support via nasotracheal intubation, endotracheal intubation or tracheostomy, including the need for suctioning or the potential need for suctioning during transport.

- 4) A patient with a transfer order requiring suctioning to maintain their airway, or a patient who requires assisted ventilation and/or apnea monitoring.

Examples – Inclusion: This criterion includes any patient requiring deep suctioning to maintain the patient’s airway.

Examples – Inclusion: This criterion includes a patient who requires or whose condition requires en route suctioning by another person as documented through a physician’s order and prior medical condition.

Examples – Inclusion: This includes a patient who is in need of a secure airway before transport is initiated. Physician orders should provide specific directives such as assisted ventilation settings, oxygen concentration or flow rate, and need for pulse oximetry.

Examples – Exclusion: This criterion does not include a patient who requires en route suctioning that can be administered by a trained caregiver available to travel with the patient.

Example – Exclusion: This criterion does not include a patient who has a longstanding established tracheostomy with spontaneous respiratory effort without need for any type of assisted ventilation or that does not require medical monitoring or suctioning.

- 5) A patient who has a transfer order for the administration or monitoring of the ongoing administration of intravenous fluids prior to, during and after transport.

Example – Inclusion: This includes a patient who has physician orders that specify the type of intravenous fluids, rate of

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administration, and site through which the fluids are to be administered.

Example – Inclusion: IV fluid administration is required during transport.

Example – Exclusion: This criterion does not include a patient with a saline lock, a heparin lock, a peripherally inserted central catheter (PICC), or an infusion port for which ongoing administration of intravenous fluids or chemotherapy is not required during the transport to the destination.

- 6) A patient to whom a chemical restraint is administered during transport or a patient who is under the influence of a previously-administered chemical restraint prior to transport. Requires a physician order for a chemical restraint that is administered for the explicit purpose of reducing a patient’s functional capacity because the patient presents a danger to physical safety of him or herself and/or others during transport. The medication type must be documented.

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Example – Inclusion: This criterion includes a patient where the chemical restraint administered requires close surveillance of a patient’s cardio-respiratory status, due to the central nervous system or respiratory system depressant resulting from the chemical restraint administered, prior to or during transport.

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Example – Exclusion: This criterion does not include a patient receiving the administration of psychotropic medications routinely taken for a pre-existing mental illness unless there is an acute exacerbation of a psychiatric condition.

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Example – Exclusion: This criterion does not include a patient receiving the administration of routinely taken sedative medications.

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- 7) A patient who has a transfer order for physical restraints that are required prior to transport and which are maintained for the duration of transport.

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Example – Inclusion: This criterion includes a patient with a physician order for physical restraint administered for the explicit purpose of reducing a patient’s functional capacity because the patient presents a danger to the physical safety of him or herself

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and/or others during transport. This criterion requires an order for the type of physical restraint and monitoring required during the transport.

Example – Inclusion: This criterion includes a patient being transported from or to a restrained facility, holding center or lockdown facility.

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Example – Exclusion: This criterion does not include a patient with an order for simple safety straps.

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- 8) A patient who has a transfer order requiring one-on-one supervision due to a condition that places the patient and/or others at a risk of harm or elopement for the duration of the transport.

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Example – Inclusion: This criterion includes a patient who has a psychiatric condition or disease who is receiving medical care for an acute psychiatric crisis.

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Example – Exclusion: This criterion does not include a patient who has a history of a psychiatric condition but is not in an acute psychiatric crisis or condition.

Example – Exclusion: This criterion does not include a patient who has a diagnosis of dementia including Alzheimer's disease, other altered mental status or neurological condition, who is easily directed.

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- 9) A patient who has a transfer order requiring cardiac and/or respiratory monitoring, or hemodynamic monitoring, prior to, during and after transport.

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Example – Inclusion: This criterion includes a patient who has been monitored via telemetry at the transferring facility for an arrhythmia, who continues to need telemetry monitoring during the transport, and who is expected to require telemetry monitoring after transport.

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Example – Inclusion: This criterion includes a patient who has an order for hemodynamic monitoring during transport.

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Example – Inclusion: This criterion includes a patient who has received a central nervous system and/or respiratory system depressant medication

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who requires cardiac and/or respiratory or hemodynamic monitoring. This criterion requires the documentation of the name, dosage, route, date and time of the medication administered. It also requires a physician's order for the specific type of monitoring required.

Example – Exclusion: This criterion does not include a patient who was not receiving cardiac monitoring or hemodynamic monitoring at the transferring facility and who is not expected to require cardiac monitoring or hemodynamic monitoring at the destination.

- 10) A patient who has a physician order for specialized handling for the purpose of positioning during transport. Requires a physician's order that documents the condition and the type of specialized handling and/or positioning that is required to transport to the destination.

Example – Inclusion: This includes a patient who requires specialized handling and positioning during transport, as well as the assistance of medically trained personnel to avoid further injury during transport. This criterion requires a physician order that documents the significant mobility deficit and the type of special positioning required.

Example – Inclusion: The patient's diagnosis, the physician's order for non-emergent ambulance transportation supporting the need for special positioning due to contractures, spica cast or recent extremity fractures, (e.g. post-operative hip) or other conditions, and the specific type of positioning required prior, during and after transport must be appropriately documented in a physician order.

Example – Inclusion: The criterion includes a patient utilizing an orthopedic device due to a medical condition requiring the use of a backboard or in halo traction. This criterion also includes patients who have external fixation, including external traction devices, which make it impractical for the patient to be positioned in a wheelchair or standard car seat. This criterion would require a physician's order for non-emergent ambulance transportation and specialized handling for an orthopedic device or condition. The order must include the specific type of positioning required at the time of transport and through transport to the destination.

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Example – Inclusion: The criterion includes a patient with a medical diagnosis of multiple myeloma who has a history of pathologic fractures compromising his spinal cord causing paraplegia.

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Example – Exclusion: This criterion does not include a patient who is bed confined but for whom there is no physician order or need for medical care, aid, monitoring, or treatment during transport as detailed in any of the above criteria.

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*\* Terms such as bedridden, bed-confined, stretcher patient or required restraints do not, by themselves, support medical necessity. The determining factor is the condition of the patient. In addition, "bed confined" is not meant to be the sole criterion to be used in determining medical necessity.*

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Example – Exclusion: This criterion does not include a quadriplegic or paraplegic patient who can be transported by wheelchair or stretcher, who does not meet any of the other criteria in this listing, or who does not have a physician order for special positioning or medical monitoring.

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Example – Exclusion: This criterion does not include a patient who has a Foley catheter, a G-tube, or other medical equipment for which there is no medical need or physician order for monitoring during transport.

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Example – Exclusion: This criterion does not include the transport of a patient with a stage I or II decubitus ulcer on the buttock with a travel time less than one hour.

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- 11) A patient who requires clinical observation is moving from one environment with 24-hour clinical observation or treatment provided by certified or licensed nursing personnel to another environment with 24-hour clinical observation or treatment provided by certified or licensed nursing personnel. This criterion is based upon a patient's need for clinical observation or treatment, prior to, during and after transport to the destination. This criterion is not satisfied based solely on the type of hospital or other facility from which the patient is being transferred to or from.

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Example – Exclusion: This criterion excludes a patient transferring from a hospital to a long term care facility that does not require clinical observation or treatment as set forth in this subsection (b)(11).

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(Source: Added by emergency at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)

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**Section 140.TABLE D Schedule of Dental Procedures**

**EMERGENCY**

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) Clinical Oral Examinations for adults age 21 and older; are limited oral examination-problem focused in conjunction with an emergency visit.

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3) 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

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- 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

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- 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



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- 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

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- 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, intracoronaral, ages 0-20 years
  - 12) Provisional splinting, extracoronaral, 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

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- 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

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- 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

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- 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

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- 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) Simple Extractions for adults age 21 and older  
Single tooth extraction
  - 32) 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
  - 4) Surgical Extractions for adults age 21 and older  
Surgical removal of residual roots

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- | ~~53~~) Other Surgical Procedures  
Surgical exposure to aid eruption, ages 2-20 years
- | ~~64~~) Alveoloplasty
  - A) Alveoloplasty in conjunction with extractions, ages 2-20 years
  - B) Alveoloplasty not in conjunction with extractions, ages 2-20 years
- | ~~75~~) 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
- | ~~86~~) 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
- | ~~97~~) Treatment of Fractures – Compound
  - A) Maxilla – open reduction
  - B) Maxilla – closed reduction
  - C) Mandible – open reduction
  - D) Mandible – closed reduction

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108) Reduction of Dislocation

- A) Open reduction of dislocation
- B) Closed reduction of dislocation

119) 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 Salzman 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) Unclassified Treatment for adults age 21 and older

- A) Analgesia, anxiolysis, inhalation of nitrous oxide
- B) Non-Intravenous Conscious Sedation

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- ~~32~~) Professional Consultation  
Consultation (narrative; diagnostic services provided by dentist other than practitioner providing treatment)
- ~~43~~) Drugs
  - A) Therapeutic drug injection
  - B) Other drugs and medicaments
- ~~54~~) Miscellaneous Services
  - A) Unspecified ~~procedures~~ procedure by report to be described by statement of attending dentist.
  - B) Dental procedures otherwise not covered for adults age 21 and older when determined by the Department to be a necessary prerequisite for required medical care.

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(Source: Emergency amended at 36 Ill. Reg. \_\_\_\_\_, effective, July 1, 2012, for a maximum of 365 days)

**Section 140. TABLE F Podiatry Service Schedule (Repealed)**

**EMERGENCY**

- ~~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~~

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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~~

e) ~~Podiatric Pathology~~

1) ~~Urinalysis~~

2) ~~Urinalysis, routine, complete~~

3) ~~Chemistry~~

4) ~~Sugar (glucose), blood~~

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- 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~~

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- ~~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 osteotomy 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 (CO<sub>2</sub>, N<sub>2</sub>), 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~~

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- 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) ~~Osteotomy, partial excision of fifth metatarsal head (e.g., bunionette, independent procedure)~~
  - L) ~~Osteotomy, partial excision of metatarsal head (e.g., metatarsectomy, partial, such as a condylectomy or excision of head of metatarsal)~~

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- ~~M) Osteotomy, partial excision of a phalanx (phalangectomy, partial such as condylectomy or excision of head of phalanx)~~
- ~~N) Osteotomy, 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 metatarsophalangeal 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 (osteoclasia), first metatarsal, for shortening, angular, or rotational correction~~

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- ~~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~~
- ~~H)~~ ~~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

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- 3) ~~Roberts Foot plate (custom made to model), pair~~
- 4) ~~Whitman Foot plate or brace (custom made to model), pair~~
- 5) ~~Thermoplastic 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 shoe 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 heels, 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~~



ILLINOIS REGISTER

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

~~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, elavi, 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: Repealed by emergency at 36 Ill. Reg. \_\_\_\_\_, effective July 1, 2012, for a maximum of 365 days)