

# Illinois Department of Healthcare and Family Services

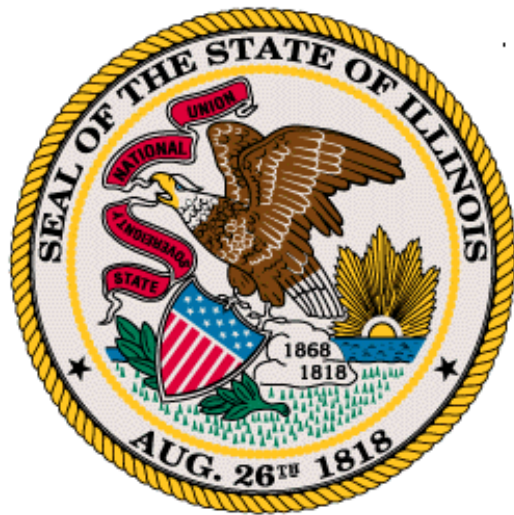
**Federally Qualified Health Centers (FQHC)**

**Rural Health Centers (RHC)**

**Encounter Rate Clinics (ERC)**

**Billing Webinar**

**September 24, 2014**



# What's New at HFS

- New links on the HFS Medical Programs website at <http://www2.illinois.gov/hfs/MedicalPrograms/Pages/default.aspx>. Please refer to the September 19, 2014 Provider Notice at <http://hfs.illinois.gov/assets/091914n2.pdf> for details.
  - **Claims Processing System Issues** will provide you with the most current system issues the Department is experiencing, as well as information regarding resolutions. This link may be found on the website at: <http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx>  
*\*\*Providers are encouraged to review this site for possible explanation to their billing questions or issues before contacting a billing consultant\*\**
  - **Non-Institutional Providers Resources** is designed to assist Non-Institutional Providers with HFS billing and payment for services, as well as provide answers to frequently asked questions and links to webinar slides. This link may be found on the website at: <http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx>
- Family Planning – Change for billing of transcervical sterilization device
- SB 741 which has now become **Public Act 0651**
- Tobacco Cessation Coverage

# Non-Institutional Providers Resources Page

- Due to time constraints today's webinar will review the most pertinent information regarding encounter clinic billing and the most up-to-date changes occurring at HFS. Please refer to the **Non-Institutional Providers Resources** page for many of the topics discussed in previous webinars.
- Please refer to previous webinar slides for additional resources at the March 25, 2014 HFS **Billing for Encounter Rate Clinics** shown as **“power point presentation”**
- Providers who have never attended the webinar sessions are greatly encouraged to review these slides. Questions are welcomed for any past webinar slides as well as the one being presented at this time.

# Public Act 0651

## Medicaid Benefit Changes

- Details may be found on the HFS website at <http://www2.illinois.gov/hfs/agency/pages/sb741factsheet.aspx>. Please note that not all PA0651 changes apply to encounter clinic billing.
- Restoration of coverage for dental care services for adults to that prior to the SMART Act effective July 1, 2014
- Restoration of podiatry services for non-diabetic diagnosis effective October 1, 2014. PLEASE NOTE: Podiatry services are not eligible to be billed by encounter rate clinics.
- Elimination of the prior authorization requirement under the four prescription policy for anti-psychotic drugs effective July 1, 2014
- Elimination of the prior authorization requirement under the four prescription policy for children with complex medical needs who are enrolled in CCE solely to coordinate care for these children, if the CCE has a comprehensive drug reconciliation program, effective July 1, 2014
- Elimination of the annual 20 visit limit for speech, occupational and physical therapies effective October 1, 2014.
- Prior approval will be required for all participants for speech, occupational and physical therapies. This requirement is currently in place for adults and will be implemented for children at a later date.

# Tobacco Cessation Counseling Services

- Please refer to the provider notice dated August 26, 2014 at:  
<http://www.hfs.illinois.gov/assets/082614n.pdf>
- Effective with dates of service on and after January 1, 2014 the Department will reimburse providers for tobacco cessation counseling services rendered to pregnant and post-partum women age 21 and over, as well as children through age 20, in accordance with the Affordable Care Act
- Tobacco cessation counseling services for the above populations are not separately payable but billable as additional detail in case of a face-to-face with a physician, APN, or physician assistant under the following procedure codes:
  - 99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
  - 99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
- Counseling sessions must be provided by, or under the supervision of, a physician or any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services

# Tobacco Cessation Counseling Services (con't)

## Duration of Counseling

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

# Tobacco Cessation Counseling Services (con't)

## ▶ Pharmacotherapy

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

# Update in Adult Dental Program Services

- Please refer to the June 26, 2014 Informational notice at:  
<http://www.hfs.illinois.gov/assets/062714n.pdf>
- Due to Public Act 0651 effective July 1, 2014, coverage for adult dental services will be restored to that prior to the SMART Act
- Pregnant women (prior to the birth of their children) are eligible for the following five preventive dental services in addition to the dental benefits listed for all eligible adults:
  - Periodic Oral Evaluation
  - Cleaning
  - Periodontal Scaling and Root Planing-4 or more teeth per quadrant
  - Periodontal Scaling and Root Planing-1-3 teeth per quadrant
  - Full Mouth Debridement



# Four Prescription Policy

- As a result of the SMART Act, HFS has reduced the number of prescriptions that can be filled in a thirty-day period, without prior authorization, to four. Information regarding this policy is posted on the web site at <http://www.hfs.illinois.gov/pharmacy/script/>
- Exceptions to the prescription policy will be allowed in certain situations, with prior approval. As a reminder, effective July 1, 2014 Public Act 0651 eliminated the prior authorization requirement anti-psychotic drugs and for children with complex medical needs enrolled in a CCE solely to coordinate their care.
- A prior approval request for exception can be initiated electronically on the MEDI system. Please refer to the September 4, 2012 informational notice entitled Drug Prior Approval/Refill Too Soon Entry System), posted on the web site at <http://www.hfs.illinois.gov/assets/090412n1.pdf>
- Effective with the December 10, 2013 provider notice at <http://www.hfs.illinois.gov/assets/121013n.pdf>, the Department will not require prior approval or four prescription policy overrides for anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder according to department records

# Affordable Care Act (ACA)

## Increased Payment for Primary Care Services

- Increased payments will apply only to services reimbursed by Medicaid fee-for-service. **For encounter rate clinics, these payments will apply only to hospital visits billed fee-for-service. Clinic encounter services are not eligible for the increased rate.**
- Please refer to the provider notice dated March 4, 2013 at:  
<http://www.hfs.illinois.gov/assets/030413n.pdf>
- Physicians must self attest they meet at least one of the criteria. The HFS 2352 Certification and Attestation form is available on the provider enrollment webpage at  
<http://www.hfs.illinois.gov/enrollment/>
- Please refer to the July 29, 2013 provider notice at  
<http://www.hfs.illinois.gov/assets/072913n.pdf> for details and billing instructions for services provided by APNs

# Affordable Care Act (ACA)

## Increased Payment for Primary Care Services

### Services eligible for the ACA increased payments:

- The ACA fee schedule for primary care services may be viewed at:
  - <http://www2.illinois.gov/hfs/SiteCollectionDocuments/ACAEMFeeSchedule8513.pdf>
- The ACA fee schedule for vaccines may be viewed at:  
<http://www2.illinois.gov/hfs/SiteCollectionDocuments/ACAVaccineFeeSchedule080713.pdf>
- The adjustment amount will be the difference between the lesser of the maximum allowed amount or the provider charge minus any TPL, co-pay, or HFS paid amount on the original claim
- A Department error resulted in ACA payments to providers for Title 21 (State Children's Health Insurance Program/CHIP) and state-funded participant eligibility categories for which increased payments did not apply. Only Title 19 (Medicaid) participant eligibility categories are eligible for the increased payments. An adjustment process is now being initiated to recoup these payments and will be identified by reason code 3317.

# Affordable Care Act (ACA)

## Increased Payment for Primary Care Services

### Adjustments with Reason Code 3314

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

### Adjustments with Reason Code 3317

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

# Reminder: Annual Medical Cards

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

# Home Health Care Services

## **Face-To-Face Requirement**

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

## **Rate Change**

- As a result of Public Act 0651, the Department will increase the rates paid to Home Health Agencies for all-inclusive intermittent visits, and for In-Home shift hourly nursing services rendered by a Certified Nursing Assistant (CNA), effective July 1, 2014
- A provider release announcing these rate changes is forthcoming. Rate changes will also be reflected on the updated home health fee schedule.

# 180 Day Time Limit for Claim Submittal

- As a result of the SMART Act, claims received with dates of service on or after July 1, 2012 are subject to a filing deadline of 180 days from the date of service
- For details and the most up-to-date list of exceptions to the 180 day timely filing deadline please refer to the timely filing documents recently posted to the Non Institutional Providers Resources webpage and announced in the September 12, 2014 provider notice at <http://www.hfs.illinois.gov/assets/091214n3.pdf>
- Please refer to the Non-Institutional Providers Resource webpage for instructions regarding how to submit requests for timely filing overrides, the departments new override request form HFS 1624, and a Q & A. Please note the HFS 1624 is not mandatory for a timely filing override request.
- *Timely filing applies to both initial and re-submitted claims*
- Claims submitted greater than 180 days but less than 365 days from the date of service will reject G55 ; Claims submitted greater than 365 days from the date of service will reject D05
- Medicare crossovers (Medicare payable claims) are subject to a filing deadline of two years from the date of service

# Co-Pays/Cost Sharing

- Co-pay amounts will *not* be reflected on the annual medical cards
- The provider notice dated March 19, 2014 and attached updated Appendix 12 at <http://www.hfs.illinois.gov/assets/031914n.pdf> provides the most up-to-date information about co-payment amounts and applicable eligibility categories.
- The Q & A document referenced in the February 14, 2014 provider notice regarding participant liability and co-payments is now available at the new Non-Institutional Providers Resources link at <http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx>
- When billing the Department *providers should not report the co-payment*, nor deduct it from their usual and customary charge, on the claim. The Department will automatically deduct the co-payment from the provider's reimbursement.
- The Department is in the process of issuing adjustments for some co-payments incorrectly taken. Please refer to the August 20, 2014 provider notice at <http://www.hfs.illinois.gov/assets/082014n.pdf> for details including explanation of the reason codes you may see on the adjustments.



# Co-Pays/Cost Sharing (con't)

- Please note the Department has implemented the co-pay for behavioral health services effective with dates of service beginning February 1, 2014. Please refer to the February 3, 2014 and March 19, 2014 provider notices at <http://www.hfs.illinois.gov/assets/020314n.pdf> and <http://www.hfs.illinois.gov/assets/031914n.pdf> for details.
- Please refer to previous webinars for a list of participants and services excluded from cost sharing
- As a reminder, Medicaid is nearly always the payer of last resort. Participants with other insurance/third party liability and Medicaid secondary may be charged the Medicaid co-payment if accepted as a Medicaid patient, but may not be charged the insurance co-payment

# Co-Pays/Cost Sharing for IHW

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

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

# Group Psychotherapy

- As a result of the SMART Act effective with dates of service on or after July 1, 2012, HFS has eliminated coverage of group psychotherapy for participants who are residents in a nursing facility, institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act. For details please refer to the provider notice at: <http://www.hfs.illinois.gov/assets/062712n1.pdf>.
- An addendum to the June 27, 2012 notice was issued by HFS on July 23, 2012 at <http://www.hfs.illinois.gov/assets/072312n1.pdf> clarifying the procedure codes affected by the change are 90853 and 90849
- Please refer to the January 30, 2013 provider notice at <http://www.hfs.illinois.gov/assets/062614n.pdf> for details regarding a policy reversal to allow mid-level staff to bill for group therapy rendered in a FQHC or RHC. This includes APNs, LCPCs, LCSWs, LMFTs, and Psychologists.

# Therapy Services

- A practitioner may charge only for an *initial* therapy treatment (prior to referral to a licensed therapist) provided in the practitioner's office by the practitioner or the practitioner's salaried staff under the practitioner's direct supervision. This service is not separately payable although billable as a detail code.
- Ongoing therapy services are only reimbursed to an enrolled individual therapist
- Individual therapists and hospitals should refer to Chapter J-200, Handbook for Providers of Therapy Services at <http://www2.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf> and the therapy fee schedule at [http://www2.illinois.gov/hfs/SiteCollectionDocuments/therapy\\_feesched.pdf](http://www2.illinois.gov/hfs/SiteCollectionDocuments/therapy_feesched.pdf) for information regarding therapy services

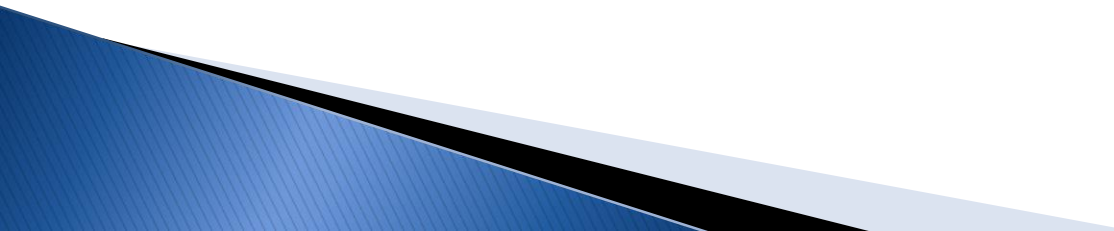
**\*Please be aware any SMART Act or Public Act 0651 changes supersede information in the handbook, which is undergoing revision\***

# Definition of an Encounter

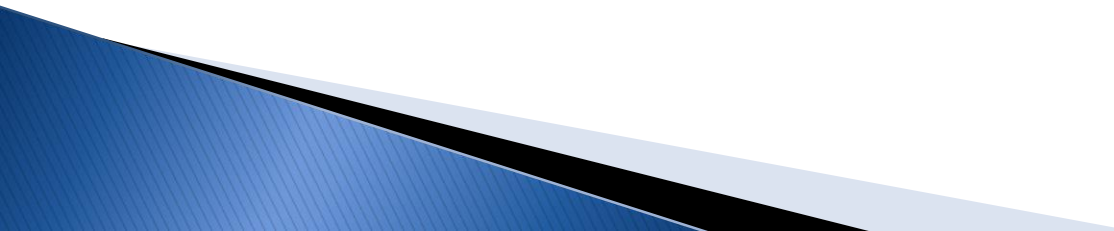
An encounter is defined as a face-to-face visit with one of the following:

- Medical encounter:
  - Physician
  - Psychiatrist
  - physician assistant
  - nurse practitioner or midwife
- Dental encounter, if the clinic is enrolled to provide dental services:
  - dentist
- Behavioral Health encounter, if the clinic is enrolled to provide behavioral health services:
  - licensed psychologist
  - licensed clinical social worker
  - licensed clinical professional counselor

# Billable Place of Service for Encounters

- Office
  - Patient's home - if the patient is homebound
  - Long Term Care facility - if it is the patient's permanent place of residence
  - School – if the clinic has a school-based or school-linked specialty
- 

# Encounter Clinic Billing

- Encounter Clinics may bill only one medical encounter per patient per day
  - If enrolled for dental services, Encounter Clinics may bill for only one dental encounter per patient per day
  - If enrolled for behavioral health services, Encounter Clinics may bill for only one behavioral health encounter per patient per day
  - If several different encounter types occur on the same date of service each encounter should be submitted on a separate claim
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# Encounter Clinic Billing (con't)

- Claims must be submitted with the encounter CPT code (T1015 or S5190) listed in the first service section along with the clinics assigned encounter rate
- If T1015 or S5190 is billed in any other service section the claim may reject for “no covered service”
- The CPT codes for the services provided must then be listed in the remaining service sections. These codes are referred to as the *detail codes* and will be reimbursed at \$0.00.
- An exception to the above is when billing for Medicare recipients – only T1015 needs to be billed to Medicare – no detail codes are required



# Encounter Clinic Billing (con't)

Detail codes billed should include all services provided so long as they are provided as part of a billable encounter, such as:

- Evaluation/Management services
- Laboratory (if CLIA) and/or x-ray services
- Immunizations administered
- Assessments/Screenings completed
- Procedures performed

# Behavioral Health Encounter Codes

## **Licensed Clinical Social Worker**

COS 58

Bill T1015 with AJ modifier plus detail code

## **Licensed Clinical Psychologist**

COS 59

Bill T1015 with AH modifier plus detail code

## **Licensed Clinical Professional Counselor**

COS 88

Bill T1015 with HO modifier plus detail code

## **Licensed Marriage and Family Therapist**

COS 88

Bill T1015 with HO modifier plus detail code

\*\*COS indicates Category of Service. The COS for which a clinic is enrolled for behavioral health services can be found on the provider information sheet.

# EPSDT Detail Codes

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

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

# EPSDT Detail Codes (Con't)

- Lead Screenings
  - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the specimen collection
  - if specimen is not being sent to IDPH and is being analyzed at the office bill 83655
- Hearing Screening
  - 92551
- Vision Screening
  - 99173
- Labs/X-rays
- Mental Health Risk Assessment
  - 99420

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

# Adult Preventive Services

- Adult Preventive Visits
  - 99385-99387 new patients
  - 99395-99397 established patients
- Immunizations
  - billable when medically necessary and administered according to CDC guidelines so long as they are provided as part of a billable encounter
- Screening for cancer

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

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

# Prenatal/Perinatal Services

- Prenatal Services
  - 0500F (initial prenatal visit) – date of the last menstrual period (LMP) must be reported when billing the initial prenatal CPT
  - 0502F (subsequent prenatal visit) – routine urinalysis is not separately reimbursable
  - 0503F/59430 (postpartum visit)
- Perinatal Depression Risk Assessment
  - H1000 (screening during a prenatal visit)
  - 99420 with HD modifier (screening during a postpartum visit)
  - Screening during the infant's visit when the mother is not Medicaid eligible is considered a risk screening for the infant ; bill 99420 with HD modifier using the infant's RIN
- Additional information is available at:  
<http://www.hfs.illinois.gov/assets/112904pd.pdf>

# Newborn Eligibility

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



# Newborn Care

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

# IHW/Family Planning

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

# Reimbursement Changes for Long-Acting Contraceptives

- Effective June 15, 2012 HFS no longer allows IUDs or implantable contraceptives to be billed through the pharmacy point-of-sale system
- The provider who inserts the IUD or contraceptive must purchase the product and bill the Department for both the product and the insertion procedure
- These products are available for purchase through the 340B Drug Pricing Program for those who are 340B providers
- For details and instructions regarding previously obtained, but unused, IUDs please refer to the June 1, 2012 provider notice at: <http://www.hfs.illinois.gov/assets/060112n.pdf>

# Long-Acting Contraceptives and Transcervical Sterilization Devices

- Please refer to the February 26, 2013 provider notice at <http://www.hfs.illinois.gov/assets/022613n.pdf> for changes in billing and payment policy for IUDs and implantable contraceptives
- Effective with dates of service beginning July 1, 2012, IUDs and implantable contraceptives may be billed fee-for-service
- Effective with dates of service beginning October 1, 2014, transcervical sterilization devices may be billed fee-for-service. A provider notice regarding this change is forthcoming.

# Billing for Long-Acting Contraceptives and Transcervical Sterilization Devices

## Billing guidelines:

- These charges should be billed at the actual acquisition cost and separate from the encounter claim for the insertion procedure
- If purchased under the 340B drug pricing program, charges should be billed at the actual acquisition cost with a UD modifier
- Reimbursement will be made at the actual acquisition cost or the state max rate on the practitioner fee schedule, whichever is less
- Reimbursement is separate from any encounter payment the clinic may receive for the insertion procedure
- Encounter clinics may bill fee-for-service LARCs and the transcervical sterilization kits and must be on a stand alone claim separate from a second claim for the encounter, which should include the insertion procedure listed as a detail code
- If the contraceptive device is not billed completely separately from the encounter or other services, the claim will reject G70

# Non-Prescription Emergency Contraception

- Please refer to the February 3, 2014 provider notice for updated information regarding emergency contraception at:  
<http://www.hfs.illinois.gov/assets/020314n1.pdf>
- Recently, the FDA approved Plan B One Step® (levonorgestrel 1.5 mg, one tablet packet) as a non-prescription product for all women of childbearing potential
- The department will continue to cover other EC products without a prescription consistent with the FDA approval
- Please Note: Effective with dates of service July 1, 2014 and after the department will no longer reimburse emergency contraceptive pills (ECPs) billed with procedure code J8499. All ECPs must be billed using S4993 for dates of service on or after July 1, 2014. This information is also included in the forthcoming provider notice regarding family planning policy changes.

# Procedure Code S5190

- Wellness Assessment, performed by non-physician; limited to FQHCs, RHCs, and ERCs
- Used instead of T1015 and cannot be billed on the same claim as T1015
- For reporting purposes only; not payable
- Must be billed with at least one additional covered HCPCS code
- Example: vaccine given by RN without physician visit
- For more information please refer to the April 23, 2012 provider notice at <http://www.hfs.illinois.gov/assets/042312n.pdf>

# Practitioner Fee Schedule

- The Practitioner Fee Schedule and Fee Schedule Key is located at:  
<http://www2.illinois.gov/hfs/MedicalProvider/FeeSchedule/Pages/default.aspx>
- Also included with the above link you will find the Modifier Listing for Practitioner Claims
- A revised fee schedule was posted on April 1, 2014, effective with dates of service beginning January 1, 2014
- Although encounter clinic visits are not reimbursed on a fee-for-service basis this is a good resource for a list of covered procedure codes



# HIPAA 5010

- The HIPAA 5010 version of the 837P was fully implemented on May 1, 2012
- The Chapter 300 Companion Guide for 5010 may be viewed at: [http://www.hfs.illinois.gov/handbooks/chapter\\_300.html](http://www.hfs.illinois.gov/handbooks/chapter_300.html)
- 5010 submissions will receive a 999 Functional Acknowledgement
- If a 999 is never received please contact 217-524-3814 for technical assistance, as this may indicate the claim/file was not successfully received
- **Please note: A second 999 Functional Acknowledgment is possible as additional audit checks are completed. A second 999 always indicates rejection of the claim/file. Please be aware of this possibility and verify that HFS has accepted all submitted files.**

# 837P HIPAA 5010

## When billing:

- Encounter claims *any date of service* – the first service section procedure code must be the applicable encounter code (either T1015 or S5190), with detail codes, including and IUD insertion procedure, on subsequent service lines
- FFS claims for IUDs and implantable contraceptives *when the date of service is on or after July 1, 2013* - do not bill the encounter code or any other detail codes. The only service line must be the product code for the IUD or implantable contraceptive.

## Billing Format

### **Billing Loop 2010AA – Segment 85**

- enter the Encounter Clinic's NPI and the clinic's taxonomy
- the NPI must be linked to the Encounter Clinic's HFS provider number *and* the HFS 16 digit payee number

### **Rendering Provider Loop 2310B – Segment 82**

- enter the rendering provider's name and individual NPI
- the rendering provider will be passed through but not utilized in processing the claim

# 837P HIPAA 5010 (con't)

## When billing:

- FFS claims when the salaried practitioner renders services in a setting other than the clinic or place of residence

## Billing Format

### **Billing Loop 2010AA – Segment 85**

- enter the NPI linked to the clinic
- the NPI must crosswalk to a payee on the rendering provider's file

### **Rendering Loop 2310B – Segment 82**

- enter the rendering provider's name, individual NPI, and taxonomy

### **Service Line**

- Bill the applicable CPT/HCPCS code
- an encounter code (T1015, S5190) is not billable

# ICD - 10

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

# Third Party Liability

- Medicaid is nearly always the payer of last resort. All known TPL must be billed before claims may be submitted to HFS.
  - ❖ Exceptions include services to women with a diagnosis of pregnancy and preventive services for children
- Client-specific TPL appears on the MEDI eligibility detail screen
- Medicare crossover claims must contain the amount paid by Medicare for each service
- When a client is identified on the HFS system as having TPL, even if the client or TPL source states the TPL is not in effect, the claim must contain complete TPL information, including:
  - TPL resource code - TPL Resource Code Directory appears in Chapter 100 Appendix 9
  - TPL status codes – TPL status codes appear in Appendix 1 of most Chapter 200 Provider Handbooks
  - Payment amounts
  - TPL date - instructions appear in Appendix 1 of most Chapter 200 Provider Handbooks

# Medical Electronic Data Interchange (MEDI)

- MEDI is available for:
  - Verifying client eligibility
  - Submitting claims
  - Checking claim status (this function is available for 90 days from bill date)
- Login and access requires a State of Illinois Digital Identity
- For new users:
  - Obtaining a State of Illinois Digital ID is a one-time process
  - Requires entry of Illinois-based information from Driver's License/State Identification Card
  - Registration must match the provider's information sheet
- There are two types of USER registration in the MEDI System:
  - Administrator (required - limit of 2)
  - Employees (no limit)

# MEDI (con't)

- ANSI 835 (Electronic Remittance Advice) is in Production
- The 835 is available to the designated payee
- HFS error codes are not included on the 835. Codes given on the 835 are national reason and remark codes which can be found at:  
<http://www.wpc-edi.com/codes>
- Providers must refer to the paper remittance advice for HFS proprietary error codes. For the HFS error code explanations please refer to Appendix 5 of the Chapter 100 Handbook for Providers of Medical Services at  
<http://www2.illinois.gov/hfs/SiteCollectionDocuments/100app5.pdf>

# MEDI (con't)

Once the Illinois Digital Identity registration is complete,  
login to: [www.myhfs.illinois.gov](http://www.myhfs.illinois.gov)

For technical assistance with the following please contact  
217-524-3814:

- Authentication error (non-password)
- Upload batch
- 835 (ERA) and 999 (FA) assistance

For technical assistance with the following please contact  
1-800-366-8768, option 1, option 3:

- registration
- digital certificate/password reset
- administrator/biller authorization



# Voids & Replacement Claims

## ➤ Voids

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

## ➤ Replacement Claims

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

# COMMON BILLING ERRORS

- A43 – service not covered ; client has IHW coverage
- C17 – place of service illogical
- C97 – no payable service on claim
- D01 – duplicate claim , previously paid
- D05 – submitted greater than 365 after date of service
- G11 – IHC PCP referral required
- G70 – Bill FP device FFS on separate claim
- R36 - client has Medicare ; bill Medicare first
- H50 – payee not valid for provider
- M93 – missing payee/multiple payees
- H55 – rendering NPI missing/invalid
- C97 – No payable service on claim
- G55 – submitted greater than 180 days after date of service, but less than 365 days after date of service
- T21 - Client has Third Party Liability

HFS remittance advice error codes are detailed in Appendix 5 of the Chapter 100 Handbook for Providers of Medical Services, General Policy and Procedures, at:

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

# Contact Numbers for Billing Questions or Prior Approval

**Main Number : 877-782-5565**

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

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

# HFS Medical Website

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

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

# Questions

