Illinois Department of Healthcare and Family Services

Federally Qualified Health Centers (FQHC)

Rural Health Centers (RHC)

Encounter Rate Clinics (ERC)

Billing Webinar

September 24, 2015

What's New at HFS?

- New Website Resources for NIPS Providers
- Provider Reimbursement
- Family Planning Policy Change: Hospital Billing and Reimbursement for Immediate Postpartum Long-Acting Reversible Contraceptives
- Payment of Cost Sharing for Medicare Advantage Plan (MAP) Members
- Illinois Medicaid Program Advanced Cloud Technology (IMPACT)
- ICD-10-CM Implementation
- Handbook for Providers of Encounter Clinic Services Reissue
  - https://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/D200.aspx

New Provider Website Resources

- The following links were added to the department website; providers are encouraged to review these sites before contacting a billing consultant.
  - **Claims Processing System Issues, added 09-19-14**
    http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx: provides the most current system issues the department is experiencing, as well as information regarding resolutions
  - **Non-Institutional Providers Resources, added 09-19-14**
    http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx: provides answers to frequently asked questions regarding participant co-pays and liability, a list of exceptions to the timely filing deadline, timely filing override request instructions and request form, and links to webinar slides
  - **Illinois Medicaid Program Advanced Cloud Technology (IMPACT), added 04-14-15**
    http://www.illinois.gov/hfs/impact/Pages/default.aspx: provides information regarding the new Medicaid Management Information System project, including on-line provider enrollment and re-validation options.

Provider Reimbursement

- Affordable Care Act Primary Care Provider enhanced payments ended with dates of service after 12-31-14, as posted at http://www.hfs.illinois.gov/assets/120314n1.pdf
  - HFS continues to finalize adjustments to 2013-2014 services
- State Fiscal Year 2016 Budget Information http://www.hfs.illinois.gov/assets/071015n.pdf
  - HFS is processing service-related claims; providers who have follow up questions regarding payment are advised to monitor the vendor payments portal on the IOC website

Hospital Billing and Reimbursement for Immediate Postpartum LARCs

- Effective with dates of service on and after July 1, 2015, HFS will allow hospitals separate reimbursement for Long–acting reversible contraceptives (LARCs) provided immediately postpartum in the inpatient hospital setting
- Payment will be made in addition to the Diagnostic Related Group (DRG) reimbursement for labor and delivery and based on the current practitioner fee schedule
- The device, HCPCS code, and associated NDC numbers in addition to the billing instructions can be referenced in the June 30, 2015 Informational Notice at http://www.hfs.illinois.gov/assets/063015n.pdf
- Practitioners not salaried by the hospital may bill the appropriate Current Procedural Terminology (CPT) code for the LARC insertion in addition to their delivery charges

Cost Sharing for Medicare Advantage Plan Members

- The June 19, 2015 Informational Notice concerning the new HFS policy can be found at http://www.hfs.illinois.gov/assets/061915n1.pdf
- For dates of service July 1, 2015 and after, providers may bill the department for Medicare co-insurance and deductibles for individuals enrolled in a Medicare Advantage Plan and Medicaid
- HFS will consider cost-sharing when the participant is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits
- Providers must submit claims with the twenty-four (24) month timely filing limit for Medicare crossovers
- The Explanation of Benefits should be reviewed to determine if the client has co-insurance and deductibles
- Non-Institutional providers are required to submit a paper HFS 3797, Medicare Crossover or 837P and institutional providers are required to submit a paper UB04 or 837I to the department
- The appropriate three digit TPL code 909 or 910 is required in conjunction with the two digit TPL Status Code

IMPACT
Illinois Medicaid Program Advanced Cloud Technology

- **IMPACT is a multi-agency effort to replace Illinois' legacy Medicaid Management Information System (MMIS) with a web-based system to give providers a more convenient and consistent user experience, and to ensure clients receive timely and high-quality Medicaid services**

- **IMPACT Home Page:** http://www.illinois.gov/hfs/impact/Pages/default.aspx

- **Provider notices addressing IMPACT:**
  - Introduction of IMPACT: http://www.hfs.illinois.gov/assets/041415n.pdf
  - Notice of suspension of paper/implementation of Phase I: http://www.hfs.illinois.gov/assets/050815n.pdf
  - Enrollment of Billing Agents: http://www.hfs.illinois.gov/assets/061615n.pdf
  - Provider educational sessions: http://www.illinois.gov/hfs/impact/Pages/ProviderOutreach.aspx
  - Requirements for enrolling: http://www.hfs.illinois.gov/assets/062415n1.pdf

IMPACT
Illinois Medicaid Program Advanced Cloud Technology (cont'd)

- On August 3, 2015, Illinois began enrolling and revalidating all Medicaid-funded providers and billing agents through the new web portal at http://www.illinois.gov/hfs/impact/Pages/Login.aspx
- Paper enrollment applications or updates are no longer accepted
- While billing/claiming processes will remain unchanged in 2015 and 2016, failure to enroll or revalidate on time can lead to payment delays
- When logging in to begin the enrollment/revalidation process, make sure to have:
  - a National Provider Identifier (NPI) Number
  - a certified W9 on file
  - renewed any professional certifications or licensures
  - the appropriate web access (an email address and an Internet browser equivalent to Internet Explorer 8 – or a more recent browser ; specifically for IMPACT, Chrome and Firefox seem to cause less functionality issues)
  - your Application ID Number – all currently enrolled providers were previously sent an application ID number in order to access their application in IMPACT. If this ID number is lost or misplaced, contact the IMPACT help desk at IMPACT.Help@Illinois.gov

ICD - 10

- The conversion from ICD-9-CM code set to ICD-10-CM code set, as federally mandated, is effective October 1, 2015. Please refer to the June 17, 2015 Informational Notice (including FAQs) at http://www.hfs.illinois.gov/assets/061715n1.pdf

- ICD-10-CM diagnosis codes will not be accepted on electronic or paper claims for dates of service prior to October 1, 2015

- ICD-9-CM diagnosis codes will not be accepted on electronic and paper claims for service dates on or after October 1, 2015

- HFS will reject claims submitted with both ICD-9-CM and ICD-10-CM diagnosis codes on the same claim

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 may not be-billed fee-for-service or as encounters 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. PLEASE NOTE: Therapy services may not be billed fee-for-service or as encounters by encounter rate clinics.

Tobacco Cessation Counseling Services

- **Effective with dates of service on and after January 1, 2014 the department will reimburse providers for tobacco cessation counseling and pharmacotherapy services rendered to pregnant and post-partum women ages 21 and over, as well as to children through age 20, as outlined in the provider notice dated August 26, 2014 posted at** http://www.hfs.illinois.gov/assets/082614n.pdf

- **Tobacco cessation counseling for the above populations....**
  - may be a billable service under either of 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
  - must be provided by a physician, physician assistant, or APN during an office visit to be considered a billable detail code for a medical encounter
  - have the following limitations 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
  - have no maximum number of counseling sessions for children through age 20

Tobacco Cessation Counseling Services (cont'd)

- **Pharmacotherapy (nicotine replacement therapy)**

- **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 at http://ilpriorauth.com/ for specific drug coverage and prior approval requirements
  - 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

- **Tobacco Quitline:**
  - Illinois Tobacco Quitline website at http://quityes.org/
  - Toll-free call 1-866-QUIT-YES (1-866-784-8937)

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 0651effective 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 0651eliminated 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

Submittal of Claims for Multi-Use Vials

- Please reference the November 10, 2014 Informational Notice at http://www.hfs.illinois.gov/assets/111014n2.pdf
- When billing the department for a multi-use vial, providers must only bill for the quantity of the drug actually dispensed
- Claims submitted for an entire vial when a partial vial was used are subject to audit and/or recoupment of the encounter payment if no other payable detail code is present on the claim
- The information contained in the notice at the link provided does not apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs)

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

- The Non-Institutional Providers Resources website at http://www2.illinois.gov/hfs/MedicalProvider/NonInstitutionalProvidersResources/Pages/default.aspx now offers Timely Filing Override Submittal Instructions in addition to a link to the HFS 1624, Override Request form and a link to FAQs

- ***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. Claims may be submitted electronically or on the paper HFS 3797 at the following address:

  HFS
  P.O. Box 19109
  Springfield, IL 62794

180 Day Time Limit for Claim Submittal (cont'd)

- Claims addressed to a HFS post office box are received M-F between 8:30 am and 5:00 pm at a distribution center for further sorting and delivery to specified locations

- Upon arrival at the Bureau of Claims Processing, paper claims are assigned a document control number (DCN) within 24 hours. The first 7 numbers of the DCN represent the Julian date the claim was received. If the claim must be routed to a different bureau for special handling, the paper claim will be physically date stamped on the day received in that bureau

- Timeliness of override requests received in the Bureau of Professional and Ancillary Services, when allowed based on exceptions to the timely filing limit as explained in the following slides, is determined by the date stamped on the claim upon receipt in the bureau

Exceptions to the 180 Day Time Limit

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

  HFS – Bureau of Professional and Ancillary Services (BPAS)

  Attn: Practitioner Billing Consultant

  P.O. Box 19115

  Springfield, IL 62794-9115

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

Exceptions to the 180 Day Time Limit (cont'd)

- Medicare denied claims – up to 2 years from the date of service. Attach to a paper claim form HFS 2360: the EOMB showing HIPAA-compliant denial reason/remark codes and cover letter stating the reason for request for timely filing override.
- New provider enrollment, provider reenrollment or addition of a new category of service or addition of an alternate payee - 180 days from the date the enrollment or update was entered on the provider file by the Provider Participation Unit (PPU). Attach to a paper claim: the HFS 1624 Override Request Form stating the reason for the override
- Retroactive recipient eligibility – up to 180 days from the system update, which may be viewed on MEDI at www.myhfs.illinois.gov when verifying eligibility. Attach to a paper claim: the HFS 1624 Override Request Form stating the reason for the override.
- TPL – up to 180 days from final adjudication by the primary payer. ***These claims may now be billed electronically. TPL information must be reported.***
- Primary TPL recoupment – up to 180 days from the date of the recoupment notification. Attach to a paper claim: a copy of the recoupment notification and the HFS 1624 Override Request Form stating the reason for the override

Exceptions to 180 Day Time Limit (cont'd)

- Split bill – up to 180 days from the date on the HFS 2432 Split Billing Transmittal/Spenddown Form. Attach to a paper claim: the HFS 2432 and the HFS 1624 Override Request Form stating the reason for the override. TPL fields must be completed.
- Replacement claims (one electronic transaction) – must be completed within 12 months from original paid voucher date to be considered timely
- Void & Re-bill (two separate transactions) – considered timely if the void transaction is completed within 12 months from original paid voucher date and the re-billed claim is received within 90 days of the void DCN. If manual override is required for the re-billed claim, attach to a paper claim: the HFS 1624 Override Request Form stating the reason for the override
- Errors attributable to the department or any of its claims processing intermediaries that result in an inability to receive, process or adjudicate a claim – the180 day period shall not begin until the provider has been notified of the error via:
  - Date on the paper voucher/remittance advice….or….
  - Fix date on the Claims Processing Systems Webpage at http://www2.illinois.gov/hfs/MedicalProvider/SystemIssues/Pages/default.aspx

Co-Pays/Cost Sharing

- Co-pay amounts will *not* be reflected on the annual medical cards
- The provider notice dated March 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 (cont'd)

Participants excluded from cost sharing include:

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

Co-Pays/Cost Sharing (cont'd)

Services exempt from cost sharing include:

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

Co-Pays/Cost Sharing (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.

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 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
  - Licensed Marriage and Family 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

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/Preventive visits should follow the posted periodicity schedule in Section 203.1 for:
  - 99381 - 99385 new patient
  - 99391 - 99395 established patient
- Developmental Screening: 96110
- Developmental Assessments: 96111
- Immunizations: 90476 – 90749
- Lead Screenings:
  - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the IDPH test kit preparation
  - if specimen is analyzed at the office bill 83655
- Hearing Screening: 92251
- 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 >85th 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
- 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 800-843-6154.

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

- The Illinois Healthy Women (IHW) program ended 12/31/14, as many participants became eligible for coverage under ACA adult provisions
- Family planning services remain covered as outlined in the Chapter A-200 Practitioner Handbook, Section A-223:
  - Bill the appropriate CPT code(s) for services provided
  - Use the FP modifier with the E/M CPT detail code
  - Use the appropriate family planning diagnosis code from the V25 series from ICD-9-CM (or corresponding ICD-10-CM for DOS after September 30, 2015) as appropriate

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

*** Reminder: IUDs, contraceptive implants, and trans-cervical sterilization devices are the only items separately reimbursable to FQHCs and RHCs from the encounter rate**

- Again, effective July 1, 2015, HFS will allow separate reimbursement to physicians for the insertion procedure when LARCs are provided immediately postpartum in the inpatient hospital setting. Please refer to the Informational Notice dated November 10, 2014 at http://www.hfs.illinois.gov/assets/111014n1.pdf

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 trans-cervical 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

- HFS strives to update the Practitioner Fee Schedule quarterly and is posted at: http://www.hfs.illinois.gov/feeschedule/
- The most recent Practitioner Fee Schedule was posted to the website in May and is effective with dates of service beginning May 1, 2015
- HFS is diligently working toward the release of the updated Practitioners Fee Schedule removing the columns indicating the 16.75% rate reduction which was effective May 1rst through June 30, 2015. Please feel free to inquire by e-mail or monitor the website for its release.
- The Practitioner Fee Schedule provides information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization. The fee schedule consists of a key, modifier listing, lab panel table with components and rates, and the listing of billable CPT and HCPCS codes.

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
- 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

Third Party Liability

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

**for discrepancies between TPL reported by participants and that seen on MEDI please contact the TPL unit at 217-524-2490

Medical Electronic Data Interchange (MEDI)

- **MEDI is available by logging in at www.myhfs.illinois.gov for:**
  - Verifying client eligibility
  - Submitting claims
  - Submitting replacement claims (bill type ‘7’)
  - Submitting voids (bill type ‘8’)
  - Checking claim status (individual claim status is available for 90 days from bill date ; batch status is available for one year 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)
  - Employees (no limit)

MEDI (con't)

- **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, then option 3:**
  - registration
  - digital certificate/password reset
  - administrator/biller authorization
- **The 835 is available to the designated payee**
  - Remittance Advice Remark Codes are national standard codes as published at http://www.wpc-edi.com/codes.
  - For HFS-specific adjudication information, refer to the paper remittance advice form HFS 194-M-1

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**
  - May be completed electronically by using bill type '7'
- **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

- C03 – illogical quantity
- C17 – place of service illogical
- C97 – No payable service on claim (encounter claims with no payable detail code)
- D01 – duplicate claim – previously paid this provider, this recipient, this DOS, this code
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 / R39 – client enrolled in managed care, provider must bill the plan
- G55 – submitted later than 180 days, but not more than one year, from date of service
- H50 – payee not valid for provider
- H55 – rendering NPI missing/invalid
- M93 – missing payee/multiple payees
- R36 – client has Medicare – bill Medicare first
- T21 -- Client has Third Party Liability
- X05 – Hospital visit disallowed
- X06 – surgical package previously paid

Chapter 100 Handbook, Appendix 5 details HFS remittance advice error codes at:
http://www.hfs.illinois.gov/assets/100app5.pdf

Contact Numbers for Billing Questions or Prior Approval

Main Number : 877-782-5565

****Claim status is NOT available by phone. Claim status is available using MEDI, the 835 ERA, and the paper remittance advice.****

- IMPACT: option 1
- UB04 Billing: option 2
- Billing for Practitioners, including Physicians, Chiropractors, APNs, LHDs, FFS Hospitals, Labs, Radiology, Podiatry: option 3, then option 1
- Billing for Audiologists & Durable Med Equip: option 3, then option 2
- Billing for Transportation : option 3, then option 3
- Billing for Optical : option 3, then option 4
- Billing for LEA, Home Health, Therapies : option 3, then option 5
- Prior Approval for DME : option 5, then option 1
- Prior Approval for Home Health/Therapies : option 5, then option 2

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