



Handbook for Practitioners Rendering Medical Services

Chapter A-200 Policy and Procedures For Medical Services

**Illinois Department of Healthcare and Family Services
Issued October 2016**

Chapter A-200

Practitioner Services

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Purpose

This handbook, along with recent [provider notices](#), will act as an effective guide to participation in the [Department's Medical Programs](#). It contains information that applies to fee-for service Medicaid providers. It also provides information on the Department's requirements for enrollment and provider participation as well as information on which services require prior approval and how to obtain prior approval.

It is important that both the provider of services and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the [Department's Medical Programs](#) policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updates are posted to the [Department's Provider Handbook website](#).

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive [e-mail notification](#) when new provider information has been posted by the Department.

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The [Recipient Eligibility Verification \(REV\)](#) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

Acronyms and Definitions

Billing Provider - A provider who submits claims and/or receives payment for an individual rendering/servicing or sole proprietor provider.

CPT - Current Procedural Terminology, as defined and published by the American Medical Association.

[Department of Healthcare and Family Services \(HFS\)](#) or (Department) - The Department of Healthcare and Family Services (HFS) or (Department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs, including All Kids, FamilyCare, Veterans Care, and Health Benefits for Workers with Disabilities (HBWD).

Document Control Number (DCN) - A fifteen-digit number assigned by the Department to identify each claim that is submitted by a provider. The format is CCYYDDDLLSSSSSS.

| | |
|--------|---|
| CC | First 2 digits of the century claim was received. |
| YY | Last 2 digits of year the claim was received. |
| DDD | Julian date (pdf) claim was received. |
| LL | Document Control Line Number (most commonly 15 for paper, 16 for paper with attachment, 17 for paper with override, 22 for electronic, 23 for electronic Medicare crossover). |
| SSSSSS | Sequential Number. |

Fee-for-Service - A payment methodology in which reimbursement is considered for each service provided rather than as part of an all-inclusive rate.

[HCPCS](#) - Healthcare Common Procedure Coding System.

[HFS 1409](#) (pdf) - The Department of Healthcare and Family Services Prior Approval Request Form.

[HFS 1977](#) (pdf) - The Department of Healthcare and Family Services Acknowledgment of Receipt of Hysterectomy Information Form.

[HFS 2189](#) (pdf) - The Department of Healthcare and Family Services Sterilization Consent Form.

[HFS 2360](#) (pdf) - The Department of Healthcare and Family Services Health Insurance Claim Form.

[HFS 2390](#) (pdf) - The Department of Healthcare and Family Services Abortion Payment Application Form.

HFS 2432 - The Split Billing Transmittal for MANG Spenddown Program Form issued by the Department of Human Services.

[HFS 3797](#) (pdf) - The Department of Healthcare and Family Services Medicare Crossover Invoice.

[HFS 3882](#) (pdf) -The Department of Healthcare and Family Services Psychiatric Residency Certification Form.

Hospital Salaried Physician – A practitioner with the cost of their services included in the hospital cost reports and with a contractual arrangement with the hospital for charges of professional services.

Hospitalist - Physicians and nurse practitioners whose primary professional focus is concerned with the general medical care of hospitalized patients.

Identification Card or Notice - The card issued by the Department to each person or family eligible under Medical Assistance, All Kids, FamilyCare, Veterans Care, Health Benefits for Workers with Disabilities (HBWD) and Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

National Drug Code (NDC) - A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. [The National Drug Code \(NDC\)](#) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

National Provider Identifier (NPI) - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

Participant - A term used to identify an individual receiving coverage under one of the Department's medical programs. It is interchangeable with the term "recipient".

Practitioner - For purposes of this handbook, a practitioner is a health care professional or entity rendering medical services and enrolled with HFS as one of the following provider types: (physician, advanced practice nurse, imaging center, independent diagnostic testing facility, portable X-ray company, school-based linked health center, local health department, independent laboratory, fee-for-service hospital, or optometrist or dentist providing medical services.)

Procedure Code - A code from the CPT or HCPCS code set.

Provider Enrollment Section (PES) - The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

Recipient Identification Number (RIN) - The nine-digit identification number unique to the individual receiving coverage under one of the Department's Medical Programs. It is vital that this number be correctly entered when billing for services rendered.

Remittance Advice - A document issued by the Department that reports the status of claims and adjustments processed; also referred to as a voucher.

Telemedicine: The use of a Telecommunication System to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location.

Telepsychiatry - The use of a Telecommunication System to provide psychiatric services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location.

Voucher - Voucher/Explanation of Benefits/Remittance Advice – a document containing an explanation of paid, rejected, suspended and/or adjusted services for charges submitted to the Department for consideration of payment.

A-200 Basic Provisions

For consideration of payment by the [Department](#) for medical services, such services must be rendered by a provider enrolled for participation in the Department's Medical Programs via the web-based system is known as Illinois Medicaid Program Advanced Cloud Technology ([IMPACT](#)).

Services provided must be in full compliance with both the general provisions contained in the [Chapter 100 Handbook](#) for Providers of Medical Services, General Policy and Procedures and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook apply to participants enrolled in traditional fee-for-service programs and do not necessarily apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Please refer to the policies and procedures of each individual plan.

Charges for services provided to participants enrolled in a Managed Care Organization (MCO) or Managed Care Community Networks (MCCNs) must be billed to the MCO or MCCN according to the contractual agreement with the MCO or MCCN. The Department is not to be billed for services if the participant is enrolled in an [MCO or MCCN](#).

Providers submitting X12 837P electronic transactions must also refer to the [Chapter 300](#), Handbook for Electronic Processing. Chapter 300 identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the [Illinois Department of Healthcare and Family Services](#).

A-201 Provider Enrollment

To comply with the Federal Regulations at [42 CFR Part 455 Subpart E - Provider Screening and Enrollment](#), Illinois has implemented an electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology ([IMPACT](#)).

Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required.

Refer to [IMPACT Provider Types, Specialties and Subspecialties](#) for additional information.

A-201.1 Physician Enrollment

A doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois (or state of practice) license to practice medicine in all its branches is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Residents generally are excluded from participation, as the cost of their services is included in the hospital's cost report. If, by terms of their contract with the hospital, they are permitted to and do bill private patients for their services, participation may be approved.
- Hospital salaried physicians, with the cost of their services included in the hospital cost reports, are not approved for participation unless their contractual arrangement with the hospital enables them to submit their own charges for professional services.
- Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools may be approved for participation in the provision of direct patient services if they maintain a private practice and bill private patients and collect and retain payments made.
- Teaching physicians who provide direct patient care may be approved for participation provided that salaries paid by hospitals or other institutions do not include a component for direct care services.

Each physician **must** enroll with the Department in order to be considered for participation and reimbursement.

Physicians rendering group psychiatric services must hold a current Psychiatric Residency Certification or a letter from the residency program verifying completion on file with the Department. The specialty/sub-specialty must be on the provider's file.

A-201.2 Advanced Practice Nurse Enrollment

An Advanced Practice Nurse (APN) who is licensed as a registered professional nurse, holds a valid license in the state of practice and is legally authorized under state law or rule to practice as an advanced practice nurse, so long as that practice is not in conflict with the Nurse Practice Act [225 ILCS 65], the Medical Practice Act of 1987 [225 ILCS 60], the Podiatric Medical Practice Act of 1987 [225 ILCS 100], the Dental Practice Act [225 ILCS 25] and implementing rules is eligible to be considered for enrollment to participate in the Department's Medical Programs. Categories of APNs include:

- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife (CNM)
- Certified Nurse Practitioner (CNP)
- Clinical Nurse Specialist (CNS)

A written collaborative agreement is required for all APNs engaged in clinical practice with a physician, podiatrist or dentist, except for APNs practicing in a hospital, hospital affiliate or ambulatory surgical treatment center, as set forth in the [Nurse Practice Act](#). The collaborating physician, podiatrist or dentist is not required to enroll with the Department. The collaborating physician, podiatrist or dentist may not, however, be terminated, suspended or barred from participating in the Department's Medical Programs.

Advanced Practice Nurses rendering psychiatric services must hold a current certification in Psychiatric and Mental Health Nursing as set forth in 68 Ill. Adm. Code 1300, Appendix A in accordance with the Nurse Practice Act.

Advanced Practice Nurses services are not reimbursable in conjunction with a hospital APL outpatient procedure.

A-201.3 Enrollment in the Primary Care Case Management Program – [Illinois Health Connect](#)

[Illinois Health Connect](#) is the Department's statewide Primary Care Case Management (PCCM) program that is available to most participants covered by an HFS medical program. Illinois Health Connect connects eligible participants to a "best fit" medical home through a Primary Care Provider (PCP) to ensure primary and preventive health information and services are being provided to the enrollee in the best setting and to increase the quality of care and more efficient utilization of resources. In addition, PCPs are provided with tools to assist them in improving the quality of care for their enrollees

Physicians, clinics, and health centers that are enrolled to participate in the Department's Medical Programs may enroll in [Illinois Health Connect](#) as a PCP. PCPs enrolled in Illinois Health Connect serve as an enrollee's medical home by providing, coordinating and managing the enrollee's primary and preventive

services, including well-child visits, immunizations, screening, and follow-up care as needed. The PCP will also make referrals to specialists for additional care or tests as needed.

PCPs enrolled in [Illinois Health Connect](#) receive a monthly care management fee for each enrollee whose care they are responsible to manage. This care management fee is paid monthly, even if the enrollee does not utilize a service that month. PCPs are to bill their usual and customary rate for services rendered and will be reimbursed for covered services at the lesser of the provider's usual and customary rate or the State's maximum reimbursement rate. Illinois Health Connect PCPs automatically qualify for the enhanced maternal and child health rates and can qualify for an annual bonus payment under the Illinois Health Connect Bonus for High Performance Program if bonus measurements are met.

The provider types listed below may serve as PCPs in the Illinois Health Connect program:

- General Practitioners, Internists, Pediatricians, Family Physicians, OB/GYNs, and other specialists.
- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and other clinics including certain specified hospitals.
- Certified Local Health Departments.
- School-Based/Linked Clinics.
- In certain instances, nurse practitioners, midwives and physician's assistants who provide services with an affiliated physician.
- Other qualified health professionals as authorized by [HFS](#).

To learn more about the Illinois Health Connect program, or to enroll as a PCP, please visit the [program website](#) or call the Illinois Health Connect Provider Helpdesk at 1-877-912-1999 (8 a.m. - 7 p.m. Monday through Friday).

A-201.4 Maternal and Child Health Program

The [Maternal and Child Health Program \(MCH\)](#) is a primary health care program coupled with case management services for children under age 21 and pregnant women enrolled in one of the Department's Medical Programs. The program is designed to ensure access to quality health care services and designed to increase provider participation through special incentives for providers of certain services to children under age 21 and pregnant women. These include increased payment rates for selected services and expedited payment.

[Illinois Health Connect](#) PCPs automatically receive the enhanced [MCH rates](#). Providers outside of the Illinois Health Connect Program may be eligible for these enhanced rates as well but must meet the following participation requirements:

- Maintain hospital admitting privileges.
- Provide periodic health screening and primary pediatric care as needed.
- Provide obstetrical care and delivery services as appropriate to the

- provider's specialty.
- Perform risk assessment for pregnant women and children.
 - Maintain 24-hour telephone coverage for consultation including ensuring that "sick" children and "at-risk" pregnant women are treated as needed, based on a triage of need.
 - Schedule diagnostic consultation and specialty visits as appropriate.
 - Provide adequate equal access to medical care for participants.
 - Communicate with the case management entity.

A-201.5 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data as it appears on the Department's files. The provider is to review this information for accuracy immediately upon receipt. If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing billing statements to ensure that all identifying information required is an exact match to that in the Department file. If incorrect, refer to [Topic A-201.7](#).

Enrollment of a provider is subject to a provisional period and shall be conditional for one-year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or dis-enroll the provider from the Medical Assistance Program without cause.

A-201.6 Enrollment Denial

When enrollment is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of enrollment are set out in [89 Ill. Adm. Code 140.14](#). Department rules concerning the administrative hearing process are set out in [89 Ill. Adm. Code 104 Subpart C](#).

A-201.7 Provider File Maintenance

The information in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it

is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via [IMPACT](#).

Provider change information must be updated via the on-line application available on the [Illinois Medicaid Program Advanced Cloud Technology \(IMPACT\) Provider Enrollment web page](#). The on-line change function is available to notify the Department of updates or changes to enrollment information for the following categories:

- National Provider Identifier (NPI).
- Provider name.
- Provider demographic (address, phone, email).
- Payee demographic (address, phone, email).
- Add a Pay To (payee).
- Close a Pay To (payee).
- Close enrollment.
- License.
- Clinical Laboratory Improvements Amendments (CLIA).

Failure of a provider to properly update the [IMPACT](#) provider enrollment system with corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider's office address and to all payees listed if the payee address is different from the provider address.

A-202 Practitioner Reimbursement

A-202.1 Charges

Practitioners are to submit charges to the Department only after services have been rendered. Charges are to be the practitioner's usual and customary charges to the general public for the services provided. To be eligible for reimbursement, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service, or within 24 months from the date of service when Medicare or its fiscal intermediary must first adjudicate the claim, unless one of the exceptions to the timely filing rule applies. Refer to the [Timely Filing Override Submittal Instructions](#) for a list of exceptions to the 180-day rule and billing instructions for each.

Charges for services provided to participants enrolled in a Managed Care Organization (MCO) or [Managed Care Community Networks \(MCCNs\)](#) must be billed to the MCO or MCCN according to the contractual agreement with the MCO or MCCN. The Department is not to be billed for services if the participant is enrolled in an MCO or MCCN.

A practitioner may charge only for services personally rendered by that provider, or that are provided under the practitioner's direct supervision in the practitioner's office by practitioner-salaried ancillary licensed or certified staff not eligible for individual enrollment, e.g., a vaccination administered by a registered nurse in the practitioner's employ. Physical Therapists, Occupational Therapists, and Speech Therapists must individually enroll with the Department and follow the billing rules and guidance contained in [Handbook for Providers of Therapy Services](#) (pdf).

A practitioner may not charge for services provided outside the practitioner's office by anyone other than the practitioner with the following exceptions:

A physician may submit a bill for services provided by a non-enrolled Advanced Practice Nurse (APN), a Physician Assistant (PA) or a Genetic Counselor, as long as such practice is in accordance with the policy outlined in this handbook or not in conflict with the following rules and regulations:

- [Nurse Practice Act \(225 ILCS 65\)](#).
- [Physician Assistant Practice Act \(225 ILCS 95\)](#).
- [Genetic Counselor Licensing Act \(225 ILCS 135\)](#).
- Department of Professional Regulations rules for administration of Physician Assistant Practice Act ([68 Ill. Adm. Code 1350](#)).
- Department of Professional Regulations rules for administration of Nursing and Advanced Practice Nursing Act – Advanced Practice Nurse ([68 Ill. Adm. Code 1300](#)).
- HFS rules for Advanced Practice Nurses ([89 Ill. Adm. Code 140](#)).

A practitioner may not charge for services provided by another practitioner even though one may be in the employ of the other. The treating practitioner, if it is a

condition of employment, may elect to have payment directed to the employing practitioner under the alternate payee option allowed in the provider enrollment process.

Exception: A practitioner is allowed to bill for a service provided by another practitioner when the second physician is “substituting” for the attending practitioner. This provision is intended to cover situations in which the attending physician is ill, on vacation, or otherwise unavailable because of an emergency situation. The substitute practitioner does not have to be enrolled in the Department’s Medical Programs, but is required to be a licensed physician as defined in [Topic A-201](#). In addition, the substitute practitioner may not be terminated, suspended, barred or otherwise excluded from participation or have voluntarily withdrawn from the program as part of a settlement agreement. The substitution time limitations are a maximum of 14 days for a single incident and up to a maximum of 90 days per year for the attending physician. If the substitute period extends beyond the 14 days per single incident, the physician must enroll with the Department.

Procedure: The attending practitioner should bill the Department under their own name and NPI, showing the name and NPI of the substitute physician in the Referring Practitioner Name and Number field. The procedure code(s) submitted must be followed by modifier Q5 in the modifier field. The attending practitioner retains the responsibility for any quality of care issues. For Department audit purposes, it would be advisable for the physician to maintain on file a copy of an agreement between him/her and the substituting practitioner.

A practitioner providing any services in a hospital setting may charge for the services only if he/she is not salaried or reimbursed by the hospital and the hospital does not include the cost of the practitioner’s services in the hospital’s reimbursable cost report. It is the responsibility of the practitioner, if charges are made for such services, to verify that the services provided are not included as part of the contract with the hospital. If the practitioner’s salary or reimbursement is included in the hospital’s cost report for direct patient care, the services of the practitioner are included in the hospital’s reimbursement.

Charges for services and items provided to participants enrolled in a Managed Care Entity (MCE) must be billed to the MCE according to the contractual agreement with the MCE. Information regarding MCE’s can be found on the [HFS Care Coordination web-page](#).

A-202.1.1 Allowable Charges by Teaching Physicians

Teaching physicians who provide direct patient care may submit charges for the services provided, if the salary paid them by the hospital or other institution does not include a component for treatment services. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment.

Charges are to be submitted only when the teaching physician seeking reimbursement has been personally involved in the services being provided using

the physician's NPI. In the case of surgery, this means presence in the operating room, performing or supervising the major phases of the operation taking personal responsibility for the services provided, and personally performing services considered necessary to confirm the diagnosis and findings. For nonsurgical patients being seen in a hospital or in other medical settings, charges are to be submitted only if the teaching physician is personally responsible for all services provided and has direct contact with the patient.

The patient's medical record must show that these requirements have been met. All such entries must be signed and dated by the physician seeking reimbursement. A signature may be actual or electronic. Signature stamps are not acceptable.

A-202.1.2 Allowable Charges by Hospital Salaried Practitioners

Inpatient services rendered by hospital salaried practitioners may be billed separately if their salary is not included in the hospital's cost report for direct patient care. If the physician's salary is included in the hospital's cost report for direct patient care, the services of the salaried physician are included in the hospital's reimbursement.

A claim may be submitted for one salaried physician involved in direct patient care in any outpatient setting in conjunction with an APL procedure. If more than one salaried physician provides services to the same participant, the services provided by additional salaried physicians are considered part of the all-inclusive rate and cannot be billed as fee-for-service. This policy excludes billing for a salaried pathologist, radiologist, nurse practitioner or certified registered nurse anesthetist (CRNA).

Procedure: Charges for the one salaried physician may be submitted on form [HFS 2360](#) (pdf) under the physician's name and NPI. Hospitals must submit charges on the UB-04 for the APL procedure.

A-202.1.3 Services Provided by Residents

When a resident provides medical services to a participant, the Department will allow reimbursement for the services, but only to the teaching physician. The teaching physician must: 1) be personally involved in the patient's care; and 2) directly supervise the resident's activities. The employing hospital and/or teaching physician must maintain verification, which is readily available to Department staff, that these requirements have been met. Such entries must be signed and dated by the physician seeking reimbursement. Signature stamps are not acceptable.

Exception: For residents beyond their first year, the Department will recognize the medical school's or sponsoring hospital's protocols in the Department's audit process if the protocol of each residency program meets all of the following: 1) identifies the level of supervision for each year of residency; 2) describes specific situations where residents may and may not function independently; and 3) specifies the manner in which documentation will be maintained to verify that the teaching

physician has personally supervised the resident to the degree required in the protocol and has participated in the patient's care to the degree specified in the protocol. The Department will accept the medical school's or sponsoring hospital's residency program supervision protocol and other medical record documentation in the determination of whether the teaching physician has provided appropriate supervision and assumed appropriate responsibility for the services provided by the resident. If the protocol and residency records are not readily available in the event of a Department audit, the medical school or sponsoring hospital will be held to the requirements specified in the first paragraph of this topic.

A-202.1.4 Allowable Fee-For-Service Charges by Hospitals

Hospitals may submit fee-for-service charges, using the hospital fee-for-service NPI, for the following services performed in the hospital outpatient setting at the hospital's main campus when there is no service billable on the UB04:

- Administration of chemotherapy for the treatment of cancer.
- Administration and supply of the following medications:
 - Chemotherapy agents for the treatment of cancer.
 - Non-chemotherapy drugs administered for conditions that result from the administration of chemotherapy and submitted with the cancer-related diagnosis.
 - Baclofen
 - Lupron
 - RhoGAM
 - Tysabri
- Reference (outside) laboratory services, see Topic 225.1.3.
- Laboratory services performed on-site, technical component only, ordered by a practitioner.
- Radiology services, technical component only, ordered by a practitioner.
- Durable Medical Equipment and Supplies.
- Speech, Physical, and Occupational Therapy.
- Audiology services.
- OB Triage (CPT 99211 with TH Modifier). Note: hospitals may not submit charges for any other Evaluation and Management service under the hospital fee-for-service provider number.
- Long Acting Reversible Contraception (LARC).
- Electrocardiogram tracings, technical component only code.

The Department requires fee-for-service claims for the professional services of salaried practitioners to be billed under the name and NPI of the practitioner who renders the service unless the practitioner's salary is included in the hospital's cost report. If the physician's salary is included in the hospital's cost report for direct patient care, the services of the salaried physician are included in the hospital's reimbursement.

The Department requires fee-for-service claims for the professional services of salaried practitioners to be billed under the name and NPI of the practitioner who renders the service.

Hospitals may not bill separately for lab, radiology, or OB triage when an APL is billed on the same day.

A-202.1.5 Allowable Charges for Services Provided at a Hospital-Owned Off-Site Facility

Facilities Located within 35 Miles of the Hospital

Hospital Billing

Charges may be submitted for services provided at an off-site hospital-owned clinic, express care or urgent/priority care facility. The hospital may bill facility charges for procedures from the Ambulatory Procedures Listing (APL) as described in the [Handbook for Hospital Services](#) (pdf). Services that fall within the limits of [Topic A-202.1.4](#) of this handbook may be billed fee-for-service.

Practitioner Billing

Professional services provided in conjunction with a procedure from the APL must be billed following the policy located in [Topic A-202.1.2](#). Other professional services such as office visits must be billed by the practitioner who rendered the service and not the hospital.

Facilities Located More Than 35 Miles from the Hospital

A salaried practitioner may submit charges for the services provided at an off-site hospital-owned clinic, express care or urgent/priority care facility. The salaried practitioner may submit charges for office visits and for only the technical component of any laboratory or radiology services performed. The interpreting practitioner must submit charges for the professional component of the laboratory and radiology services. Charges submitted for any office visits, laboratory or radiology services performed must be submitted with place of service “office”. The salaried practitioner may request that the hospital’s CLIA be posted to the practitioner’s enrollment file.

A-202.1.6 Allowable Charges for 340B Providers

An HFS enrolled provider who is eligible to participate in the [340B Federal Drug Pricing Program](#), as defined in Section 340B of the federal Public Health Services Act, shall enroll in that program. HFS enrolled providers who are also enrolled with the Department of Health and Human Services as a 340B provider must use 340B purchased drugs for Medicaid covered participants.

An HFS enrolled provider who is also enrolled in the 340B Federal Drug Pricing Program must charge the Department no more than the actual acquisition cost for the drug product plus the appropriate Department established 340B dispensing fee as noted on the [Practitioner Fee Schedule](#).

Providers must identify 340B purchased drugs by reporting modifier “UD” in conjunction with the appropriate drug CPT or HCPCS code.

A-202.2 Claim Preparation and Submittal

For general information on policy and procedures regarding claim submittal, including billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to the [Chapter 100 Handbook](#). Refer to Appendices A-1 and A-2 for technical guidelines to assist in claim preparation and submittal.

A-202.2.1 Paper Claim Submittal

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. The Department offers a claim scannability/imaging evaluation. Turnaround on a claim scannability/imaging evaluation is approximately seven to ten working days, and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address:

Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, HFS 1444. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use HFS 2248, Special Approval Envelope. A non-routine claim is any claim to which any other document is attached.

If envelopes are unavailable, the claims can be mailed to:

HFS 2360 (Health Insurance Claim Form) **without** attachments:

Healthcare and Family Services
Post Office Box 19105
Springfield, IL 62794-9105

HFS 2360 (Health Insurance Claim Form) **with attachments**:

Healthcare and Family Services
Post Office Box 19118
Springfield, IL 62794-9118

HFS 3797 (Medicare Crossover Invoice) **with and without** attachments:

Healthcare and Family Services
Post Office Box 19109
Springfield, IL 62794-9109

Non-routine claims may not be electronically submitted.

Providers must use the Department's original claim forms. Carbon copies, photocopies, facsimiles, or downloaded forms are not acceptable. Forms and envelopes should be requested on the Department's [website](#).

A-202.2.2 Electronic Claim Submittal

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in the [Chapter 100 Handbook](#) and [Chapter 300](#).

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims.

A-202.3 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

For participants eligible for Medicare Part B benefits, payment will be considered on the cost-sharing and/or for Department's Medical Programs covered services not covered by Medicare. Refer to the [Chapter 100 Handbook](#) for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

A-202.4 Fee Schedule

The [fee schedule](#) of allowable procedure codes and special billing information is available on the Department's website.

A-203 Covered Services

Covered services are those reasonably necessary medical and remedial services, which are recognized as standard medical care, required for immediate health and well-being because of illness, disability, infirmity or impairment. Refer to [Chapter 100](#) for a general list of covered services.

While various procedure codes may be used to designate services provided or procedures performed, such usage does not necessarily assure payment. Any question a practitioner may have about coverage of a particular service is to be directed to the Department prior to provision of the service.

A-203.1 Referral Requirements

A practitioner should only refer a participant to a participating source of medical care if the care and service for which the referral is made are medically necessary, covered under the Department's Medical Programs, and are not available locally.

If the necessary services are available locally, and referral is made to a non-local provider for the preference or convenience of the practitioner or the participant, the Department will not assume responsibility for related expenses involved, such as transportation costs, etc.

A-203.1.1 PCP to PCP and PCP to Specialist Referrals

Recipient Restriction Program (RRP)

When a participant is in the RRP, all non-emergency services require written prior authorization from the Primary Care Physician (PCP) designated on the restricted participant's eligibility file. The rendering provider is responsible for obtaining a completed form [HFS 1662 Primary Care Provider Referral Authorization](#) (pdf) from the PCP and attaching the form to the claim form submitted to HFS for the service.

Illinois Health Connect PCP Referrals

Illinois Health Connect requires a participant to be seen by his/her own PCP or by a practitioner or clinic affiliated with the PCP. PCPs seeing participants enrolled in Illinois Health Connect who are not enrolled on their panel (or on an affiliated PCP's panel) must obtain a referral from the participant's PCP. If a claim requires a referral from the participant's PCP, but no referral is on file, the claim will be rejected. For information regarding direct access services that do not require a PCP referral, please refer to the [Illinois Health Connect Primary Care Provider Handbook](#).

Specialist Referrals

A specialist may choose to enroll with HFS as a PCP for certain participants. If the specialist is enrolled as a PCP with HFS, a referral will be required when rendering services to any participant not on his primary care roster.

Providers who are not enrolled as PCPs, including specialists or PCPs who provide direct access services as listed in the [IHC Handbook](#) do not need a referral from a participant's PCP at this time. Providers will be informed via an informational notice when these services will require a referral.

A-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs, in accordance with [89 Ill. Adm. Code 140.6](#). See [Chapter 100 Handbook](#) for general services and supplies for which payment will not be made. In addition, the following services are excluded from coverage in the Department's Medical Programs.

- Examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from non-medical funds. Practitioners are to follow specific billing instructions given when such a request is made).
- Services provided in Federal or State institutions.
- Sterilization of a mentally incompetent or institutionalized individual or an individual who is less than 21 years of age.
- Diagnostic and/or therapeutic procedures related to fertility, e.g., tubal or vasectomy reversal or pharmaceuticals.
- Those prosthetic devices inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function or eliminate a functional disability. (**Note:** Does not apply to breast prosthetic devices provided following cancer surgery.)
- Autopsy examination.
- Artificial insemination, in-vitro fertilization, or any other form of infertility treatment.
- Abortion, except in accordance with [89 Ill. Adm. Code 140.413\(a\)\(1\)](#).
- Medical or surgical transsexual treatment services for service provided prior to April 1, 2015.
- Subsequent treatment for venereal diseases when such services are available free of charge through State and/or local health agencies.
- Dietitian counseling.

Refer to [89 Ill. Adm. Code 140.6](#) for a complete list of services that are not covered under the Department's medical assistance programs.

A-205 Record Requirements

Practitioners must maintain an office medical record for each participant. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific practitioners rendering services.

The record is to include the essential details of the participant's health condition and of each service provided. Any services provided to a participant by the practitioner outside the practitioner's office are to be documented in the medical record maintained in the practitioner's office. All entries must include the date, time and signature of the practitioner rendering the service and must also be legible and in English. Records, which are unsuitable because of illegibility or language, may result in sanctions if an audit is conducted. Transcription may be required for purposes of peer, quality of care, or utilization reviews by the Department.

The record requirement for a consultation is a copy of the report that was made available to the practitioner requesting the consultation.

For participants who are hospitalized or in a long term care facility, the primary medical record indicating the participant's health condition and treatment and services ordered and provided during the period of hospitalization or institutionalization may be maintained as part of the hospital or facility chart. However, an abstract of the hospital or facility record, including diagnosis, treatment program, signature of the rendering practitioner, dates and times services were provided and recommendations, is to be maintained by the practitioner as an office record to show continuity of care.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, practitioners should be aware that the medical records are a key document for post payment audits.

Department requirements on retention of records as stated in the [Chapter 100 Handbook](#) are applicable to X-rays and records of film-like nature. The retention requirements are not intended to replace professional judgment nor do they supersede record retention requirements under law or regulations of other agencies. The practitioner may choose to retain records beyond the Department's required period.

The Department has no objections to microfilming X-rays when it is done in compliance with applicable State laws.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

A-220 Evaluation/Management Services

A-220.1 PCP Referrals

[Illinois Health Connect](#) requires its participants to be seen by their own PCP or a practitioner or clinic affiliated with the PCP. PCPs seeing participants enrolled in Illinois Health Connect but not enrolled on their panel, or on an affiliated PCP's panel on the date of service, must obtain a referral from the participant's PCP in order to be reimbursed by HFS for services provided. Claims that require a referral from the participant's PCP, but no referral is on file, will be rejected.

Care provided by providers who are not enrolled as PCPs, including specialists or PCPs who provide direct access services will not need a referral from a participant's PCP at this time. Providers will be informed via an informational notice when these services will require a referral.

A-220.2 Office or Other Outpatient Visits

Charges may be submitted for evaluation and management services and surgical services provided by a practitioner in the office setting that are essential for the diagnosis and/or treatment of specific illness, surgical condition, or injury. The selection of an office visit CPT code is to be based on the primary reason for the visit, the level of service provided, and whether the visit is for a new or an established patient.

The Department covers more than one office appointment per day when medically necessary. When a participant has multiple medical appointments on the same day, reimbursement can be made for the services of different practitioners, seeing the participant in separate sessions and for different conditions or levels care when medically necessary.

Example #1: A participant sees his primary care physician and later that same day sees a specialist for focused care for the same condition. The services of both may be covered when the HFS 2360 is accompanied by documentation of the medical necessity of the additional visit.

Example #2: A participant sees two practitioners on the same day for completely different diagnoses/conditions. Each practitioner is eligible for reimbursement.

Example #3: A participant sees a practitioner but returns later that same day for an unforeseen occurrence. Charges may be submitted by the same practitioner seeing a participant twice on the same day for completely different diagnoses/conditions. Both visits should be billed with a diagnosis code and office visit procedure code based on the primary reason for the visit and level of service provided. The second procedure code must be submitted with modifier 25 to indicate it was a separately identifiable E/M service. The [HFS 2360](#) must be accompanied by the office documentation for each visit.

A-220.2.1 Multiple Visit Codes during the Same Session

A preventive medicine CPT code and an office or other outpatient evaluation and management CPT code during the same session are not separately reimbursable.

The practitioner is to submit the single evaluation and management service code that best describes the actual services rendered.

Example: a participant is seen for a preventive medicine visit and also complains of a sore throat. Only one evaluation and management service code may be covered.

A-220.2.2 Therapeutic and Diagnostic Procedures Performed during the Office Visit

When a therapeutic procedure is performed during an office visit, reimbursement will be made for the service with the higher State maximum allowable rate, either the visit or the procedure, but not for both.

Exceptions:

- (1) The evaluation and management is an initial visit.
- (2) The patient's condition required a significant, separately identifiable service above and beyond the therapeutic procedure. In such case, the E&M CPT code with modifier 25 must be submitted on the paper [HFS 2360](#) (pdf) with supporting documentation attached.
- (3) Insertion, removal, or removal and reinsertion of a long-acting reversible contraceptive (LARC) is separately reimbursable from an evaluation and management service. In such case, the E&M CPT code must be submitted with modifier 25.

When a diagnostic procedure is performed during an office visit, both the procedure and the visit are separately reimbursable.

A-220.2.3 New Patient vs. Established Patient Classification

A participant may be designated as a “new patient” only once in a lifetime by an individual practitioner, partner of the practitioner or collectively in a group regardless of the number of practitioners who may eventually see the participant. When a patient is transferred within a group practice setting, a new patient procedure code is not to be used. The visit is classified as for an established patient.

A-220.2.4 Preoperative Visit

When the decision to undergo surgery occurs within a day before the surgery procedure is performed, and the visit includes the preoperative evaluation and management services, the visit is payable. The consult or evaluation and

management CPT code should be submitted with the appropriate decision-for-surgery modifier documenting that this visit was not done solely for the purpose of completing the preoperative history and physical. A visit separate from the decision for surgery visit that is done specifically for the purpose of completing the preoperative history and physical exam is considered part of the surgical package and is not separately reimbursable.

A-220.2.5 Preventive Services

Certain preventive services are covered for participants of all ages. Providers should identify preventive services, using the appropriate CPT code(s) or HCPCS code(s), diagnosis codes, and, when applicable, modifiers.

When the purpose of the visit is preventive in nature, services are rendered on a periodic schedule as dictated by age and risk factors. Services rendered primarily for preventive purposes should be submitted using the age-appropriate preventive medicine evaluation and management service code. Such services are not subject to cost sharing.

When preventive services are provided as a part of a problem-focused visit, the office or other outpatient evaluation and management procedure code is to be used instead of the preventive medicine code. Such a visit is subject to cost sharing.

For most preventive services, children are considered to be ages birth through 20 years and adults are considered to be ages 21 years and older.

Exception: Immunizations. The Vaccines for Children (VFC) program provides free vaccines to enrolled providers for children ages birth through 18 years who are enrolled in Title XIX (19), and providers may only bill HFS an administrative fee under the specific vaccine product procedure code. For all other participants, providers should bill HFS their usual and customary charge for the vaccine product under the specific vaccine product procedure code.

A-220.2.5.1 Preventive Services for Children

Children covered by the [Department's](#) Medical Programs receive preventive health screening services, including immunizations, objective developmental screening, dental care, lead screening, vision screening and risk assessments, through the Illinois' Early Periodic Screening and Diagnostic Treatment (EPSDT) program. EPSDT services must be provided in full compliance with applicable federal and State laws and regulations. The [Chapter HK-200 Handbook](#) for Providers of Healthy Kids Services contains specific information regarding EPSDT services, periodicity schedule, and benefits available to HFS' Medical Program participants who are under the age of 21.

Limits:

In addition to the periodic services schedule as shown in the Chapter HK-200, one inter-periodic screening visit is permitted per year.

Procedure: When using the Preventive Medicine Services CPT codes to bill for a well-child visit, the following components must be performed according to the CPT guidelines: evaluation and management of a patient including an age and gender appropriate history, physical, developmental and mental/psychological examination, counseling and anticipatory guidance/risk factor reduction interventions and ordering of appropriate immunizations(s) and laboratory/diagnostic procedures.

Note: Component parts of the well child screening exam, such as objective developmental screening, risk assessment, immunizations, lead screening, objective hearing and objective vision screening may be billed separately, using the appropriate procedure code(s).

A-220.2.5.2 Preventive Services for Adults

Adult preventive services are those services rendered for the prevention or diagnosis of a primary disease, or the prevention of complications of a chronic disease. Covered services include preventive evaluation and management office visits, immunizations for participants 21 years and older when administered in accordance with the [Center for Disease Control's \(CDC\)](#) recommended guidelines, screenings for cancer, and diagnostic tests and procedures.

Limits:

One adult preventive medical visit is allowed per year (333 days). One additional preventive medical visit may be allowed within that same time frame when rendered by a new primary care physician (PCP) or for a female annual exam visit.

Procedure: Providers should bill using the appropriate procedure code for the evaluation and management service. Additional risk assessments, diagnostic tests performed, and immunizations may be billed separately, using the appropriate procedure code(s).

A-220.3 Hospital Outpatient Services

A-220.3.1 Referred Services

A practitioner may refer participants for essential services such as laboratory tests, X-ray examinations, etc., that are provided by a hospital on an outpatient basis. Charges may not be made by the practitioner for the referral or for the services not personally provided by the practitioner.

A-220.3.2 Non-Emergency Services

When a practitioner sees a participant in the outpatient department of a hospital on a non-emergency basis, for the convenience of either the participant or the practitioner, the visit is considered the same as an office visit.

Procedure: If a charge is being submitted for the visit, the appropriate evaluation and management CPT code is to be entered on the billing form. The place of service (POS) must be “11”, Office. Charges are to be made for procedures as indicated for Evaluation and Management Services, [Topic A-220](#). For POS “11”, the claim should be submitted under the rendering practitioner’s name and NPI, rather than the hospital.

A-220.4 Hospital Observation Care

A practitioner may charge for hospital observation care by using the appropriate CPT codes and in accordance with CPT guidelines. If the participant is admitted to the hospital on the same service date as the observation, a charge may be submitted only for the initial inpatient visit. No payment will be made for the observation services. If the participant is seen in the emergency room and placed in observation by the same practitioner, a charge may be submitted for the observation care only.

Payment will not be allowed for observation care for consecutive dates of service. Also, only one observation CPT code may be billed. The code for observation care “discharge” is not a covered service.

Payment is not allowed for observation care for obstetrical cases in labor if the participant is admitted to the hospital from concurrent observation and delivers the same day.

A-220.5 Hospital Inpatient Services

A practitioner may admit a participant for essential inpatient hospital services in connection with covered treatment of an illness or injury. The practitioner should assure that the participant meets the established inpatient criteria.

Billing statements submitted for hospital visits are to show the appropriate CPT code designating the level of care provided. Practitioners rendering services in a partial treatment program must follow CPT guidelines.

A-220.5.1 Initial Hospital Care

The admitting practitioner may charge for the initial hospital care of the participant only if this has not previously been provided in the practitioner’s office or on an outpatient basis prior to the scheduling of the hospital admission. The initial hospital care includes comprehensive history, physical examination, and the initiation of the diagnostic and treatment program. Only the admitting practitioner named on the admission History and Physical reports is eligible for payment for the initial hospital visit for a single hospital stay.

After the day of admission, the attending practitioner may bill one subsequent visit per day. When the participant’s condition warrants the services of one or more

additional practitioners of different specialties, charges are to be submitted as discussed in [Section A-220.8.1](#), Concurrent Care.

Payment is not allowed for a subsequent visit by the same practitioner who performs/bills for a diagnostic or therapeutic procedure on the same date of service.

All visits and services for which charges are made must be documented in the participant's hospital record.

A-220.5.2 Utilization Review

A practitioner must certify for each participant that inpatient services in a hospital are or were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before HFS authorizes payment.

The medical need for hospital admission and the length of hospitalization are monitored and controlled by the Department's [Quality Improvement Organization \(QIO\)](#).

The Department or its designated agent may conduct medical reviews. Medical review shall be used to ensure the appropriateness and medical necessity of selected acute inpatient stays. Medical review may be completed for medical necessity of admission, length of stay, and/or quality of care. The Department or its agent use specified standard review criteria to review all or a portion of acute inpatient stays. If there is any change in the review criteria, the Department will give providers a minimum of thirty (30) days written notice before the change is implemented.

The Department requires prepayment utilization review in compliance with [Section 1152 of the Social Security Act](#) and 42 CFR Subchapter F, and in accordance with [89 Ill. Adm. Code Section 148.240](#), of various types of hospital care, e.g., psychiatric care. The Department may use prepayment, post payment and/or concurrent or other review processes for acute inpatient stays. The Department may provide a reconsideration process when a denial decision has been reached on all or part of an acute inpatient stay when requested by the provider.

The representative of the QIO will notify the practitioner when a determination has been made that continued acute inpatient hospitalization is not essential. Charges for practitioner services provided during an unauthorized period of hospitalization are not to be submitted for payment.

If a practitioner questions a determination that continued hospitalization is non-essential, the practitioner should contact the Medical Director of the [QIO](#).

A-220.6 Consultations

A consultation is the evaluation and management service rendered by a practitioner, at the request of another practitioner, with respect to the diagnosis and/or treatment

of a particular illness or condition involving the participant, with the consultant not assuming direct care of the participant. The physician consultant may order or perform diagnostic services to arrive at a decision and/or recommendation regarding a participant's condition and plan of treatment. The consulting practitioner is usually a specialist in a different field of medicine than the attending practitioner.

The consultation claim must be submitted with the name and NPI of the referring practitioner in the appropriate fields. A written report from the consulting practitioner to the requesting practitioner is to be included in both the consulting and referring practitioner's medical records.

A referral for evaluation and treatment of the participant for total care or the referred condition only is considered medical care, and charges are to be submitted using the appropriate evaluation and management CPT code(s).

A-220.6.1 Second Surgical Opinion

Payment is allowed for a second surgical opinion consultation when it is medically necessary. Submit paper HFS 2360 with documentation.

A-220.6.2 Consultation Requested By a Third Party or Agency

Charges are not to be submitted to the Department for a consultation, medical opinion, or report, such as a disability determination, that is requested by other parties or agencies.

A-220.6.3 Repeat Consultation

A claim submitted for a repeat consultation for a participant must include the diagnosis pertinent to that service. A repeat consultation within a six-month period is not allowed for the same diagnosis or condition. In such case, the practitioner must submit the appropriate evaluation and management CPT code for the level of service provided.

A-220.6.4 Psychiatric Consultation

A psychiatric consultation includes psychiatric history, determination of mental status, diagnosis, and conference with the primary practitioner. The psychiatric provider must bill the appropriate consultation CPT code for the level of service provided accompanied by modifier HE.

A-220.6.5 Consultation within a Day of Surgery

A consultation by the operating surgeon within a day before surgery is payable under two conditions:

- The procedure was performed for a traumatic event. A traumatic event is defined as an emergency admission, complications of an emergency nature, or traumatic conditions such as acute appendicitis or fractured hip, or
- The consultation was not performed solely for the purpose of completing the preoperative history and physical, and the evaluation and management code was submitted with the appropriate “decision for surgery” modifier.

A charge submitted by the operating surgeon for a visit performed solely for the purpose of completing the preoperative history and physical is not reimbursed separately.

A-220.6.6 Inpatient Consultation

A copy of the consultation report must be part of the participant’s hospital record. The attending practitioner’s notes are to show that a consultation was requested and the reason for the request.

A-220.6.7 Telehealth

Telehealth is the use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through “store and forward” applications. The telecommunication system must, at a minimum, have the capability of allowing the consulting practitioner to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs. For additional telehealth information, see [89 Ill. Adm. Code 140.403](#).

Telephones, facsimile machines, text, and other electronic mail systems are not acceptable telecommunication systems.

Telehealth services include telemedicine as well as telepsychiatry. Under the Department’s telehealth policy, eligible providers will be paid as either an originating site or distant site. Refer to Appendix A-10 for billing examples.

Originating Site (Patient Site)

The originating site is the location where the participant receiving the telehealth service is located. HFS recognizes the following as valid originating sites: physician’s office, podiatrist’s office, local health department, community mental health center, and outpatient hospital.

Originating site providers may submit claims for a facility fee for each telehealth service encounter using HCPCS Code Q3014/Telehealth Originating Site Facility Fee. Providers eligible to receive a facility fee are physician's office, podiatrist's office, local health departments, community mental health centers and outpatient hospitals. When the originating site is an encounter rate clinic, the maximum reimbursement will be the facility's medical encounter rate.

For telemedicine services, a physician or other licensed health care professional must be present at all times with the patient at the originating site.

For telepsychiatry services, a physician, licensed health care professional or other licensed clinician, mental health professional (MHP), or qualified mental health professional (QMHP), as defined in [59 Ill. Adm. Code 132.25](#), must be present at all times with the patient at the originating site.

Distant Site (Provider Site)

The distant site is the site where the provider rendering the telehealth service is located. Maximum reimbursement to Distant site providers shall be the Department's rate for the CPT code for the service rendered. The appropriate CPT code must be billed with modifier GT (via interactive audio/video telecommunication systems).

Enrolled distant site providers may not seek reimbursement from the Department for their services when the originating site is an encounter clinic. The originating site encounter clinic is responsible for reimbursement to the distant site provider.

Non enrolled providers rendering services as a distant site provider shall not be eligible for reimbursement from the Department, but may be reimbursed by the originating site provider from their facility fee payment.

For telemedicine services, the provider rendering the service at the distant site can be a physician, physician assistant, podiatrist or APN who is licensed by the State of Illinois or by the state where the participant is located. Services rendered by an APN can be billed under the collaborating physician's NPI, or if the APN is enrolled, under the APN's NPI. When medically appropriate, more than one Distant Site provider may bill for services rendered during the telehealth visit.

For telepsychiatry services, the provider rendering the service at the distant site must be a physician licensed by the State of Illinois, or by the state where the patient is located, who has completed an approved general psychiatry residency program or a child and adolescent psychiatry residency program. To be eligible for reimbursement for telepsychiatry services, physicians must enroll in the correct specialty/sub-specialty in IMPACT.

A-220.7 Emergency Services

Emergency services are those services which are provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and

health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

If the participant presents at a hospital for emergency care, the hospital's emergency department must provide the initial service and the initial service must be directed or coordinated by the emergency department physician.

Payment for emergency services will be made for either the visit or for specific procedures performed, such as suturing, lavage, application of cast, etc. Payment will be made for the service with the higher State maximum allowable rate.

The emergency room practitioner may not submit separate charges for the interpretation of X-rays or EKGs.

When the practitioner is assigned to the emergency department, use the appropriate CPT code or evaluation and management CPT code for emergency department services. In this situation, the practitioner must bill using his/her name and NPI.

Under no circumstances may the hospital bill the practitioner's service. Refer to A-202.1.4 Allowable Fee-For-Services Charges by Hospital.

A-220.8 Critical Care Services

When a participant receives critical care services in the inpatient, outpatient or emergency room setting, the practitioner is to bill using the appropriate critical care evaluation and management CPT codes.

Payments will be allowed to one practitioner for a maximum of one and one half (1 ½) hours of critical care daily for up to ten (10) days per hospital stay for a single participant.

Note: A practitioner may bill the CPT code for an additional thirty (30)-minute increment once per day per patient. A quantity of "1" should be entered in the Days/Units field when billing for this service. Do not use this field to indicate time. The same practitioner may bill for both the first hour and the additional thirty (30) minutes, or two (2) different practitioners may bill the two (2) services. However, payment will be limited to one (1) initial and one (1) subsequent critical care CPT code per day per patient.

The maximum allowable of ten (10) days of critical/intensive care per hospital stay applies whether the service dates are consecutive or intermittent.

Note: Individual consideration will be given to charges for more than ten (10) days of critical care when documentation of medical necessity is submitted with the paper [HFS 2360](#) (pdf). This documentation must be in the form of a critical care progress note with the rendering provider's name on it for each date of service beyond the

first 10 days. The Department will determine if payment can be made for any additional days based upon this documentation. Rejected services should be re-billed using appropriate evaluation and management CPT codes for subsequent hospital care/visits.

Payment is not allowed for postoperative critical care visits by the surgeon for surgical procedures that routinely require critical/intensive care for one or more days. This postoperative time period includes the day of surgery and thirty (30) days after surgery. Refer to surgical indicators listed on the fee schedule for more information.

The critical care visit includes certain services for which separate payment is not allowable on the same day by the same practitioner, e.g. gastric intubation, ventilator management, or the interpretation of diagnostic tests. Refer to the CPT code description for services included in critical care visits. When the same practitioner performs a procedure outside the all-inclusive list of codes, as well as providing the critical care, payment will be made for the service with the higher state maximum allowable fee.

A-220.8.1 Concurrent Care

When a participant requires the specialized service(s) of an additional practitioner(s), either concurrently or intermittently during a period of hospitalization, reimbursement can be made for the services of both the attending and consultant practitioners with documentation of medical necessity. Each practitioner must identify the diagnosis he/she is personally treating.

There must be a clearly identified attending practitioner who is responsible for ordering the consultation and approving continuing concurrent care by specialists.

The attending practitioner must assume sole responsibility for the care of the participant as soon as the specific need for consultation and concurrent care is met.

Legible documentation is required for payment of concurrent care and must include all of the following:

- The initial request by the attending practitioner with specific reason for the consultation.
- The consultation report by the specialist, which should include among its recommendations whether concurrent care is required and for what period. The attending practitioner must indicate agreement with a recommendation for concurrent care in the medical record.
- A written justification (a copy of the progress note for each specific DOS) that the services required are beyond the scope of the attending practitioner. In general, these will be when:
 - The participant's condition is severe or complex, or when there is an acute exacerbation or deterioration of the participant's condition, or
 - There is a complicated diagnostic regimen required, particularly one requiring the application of specific medical technology typically within

- a sub specialist domain, or a complicated therapeutic regimen requiring frequent monitoring or changes, or
- A specified expertise of the specialist is required, for example, in infectious disease, oncology or others, or
- A team approach is required, for example, in trauma care, or
- General medical care is concurrently required when limited specialists, for example, ophthalmologists or others, admit a participant with chronic medical conditions requiring active treatment.

Procedure: Concurrent care charges must be submitted on the paper [HFS 2360](#) (pdf), with the appropriate CPT code in Field 24C. A copy of progress notes for each specific date of service must be attached to the claim.

A-220.9 Long Term Care Facility Visits and Procedures

Charges may be made for a long term care facility visit and for any procedures performed by the practitioner at the time of the visit in accordance with policy applicable to office services (see [Topic A-220.2](#)).

A practitioner may submit charges for essential services to a participant in the participant's place of residence (i.e., home, long-term care facility, or sheltered care and other custodial facility) when the participant is physically unable to go to the practitioner's office. The appropriate CPT code and [place of service](#) code are to be used for the specific service provided. All services provided by a practitioner to a participant in a long-term care facility are to be documented in the participant's record maintained in the facility.

A-220.9.1 Referrals

A practitioner may refer a participant in a long-term care facility for covered services to another practitioner when there is an identifiable medical need of the participant for the specific type of service. The practitioner to whom referral is made is responsible for obtaining any necessary authorization from the Department prior to rendering the service.

A-220.9.2 Certification of Need Visits

Initial certification and periodic recertification by the attending practitioner of a participant's need for long term care are required by federal regulations. If the practitioner must make a special visit to meet these federal requirements and the participant is unable to go to the practitioner's office, such a visit will be allowed as an essential brief service visit for an established patient.

A-220.9.3 Non-covered Services

Services for which payment will not be made when rendered in the long-term care setting include, but are not limited to, the following:

- Routine, non-individually essential visits.
- Screening services.
- Visits to a participant eligible for Medicare benefits when determined by Medicare to not be medically necessary.
- Non-emergency services to a participant by a practitioner other than the attending practitioner without referral from the attending and participant's knowledge and permission.

In addition to the above, no charges may be made for services provided to participants in a long-term care facility by a practitioner who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) of such facility except:

- Emergency services provided for acute illness.
- When there is no other available facility in the area for essential treatment for short-term care pending transfer.
- When there is no comparable facility in the area.

A-220.10 Prolonged Practitioner Services

Payment is allowed for prolonged practitioner service with direct (face-to-face) patient contact when the medical condition of the participant necessitates such care provided in the Outpatient Hospital, Emergency Room or Inpatient Hospital setting. No payment is allowed for prolonged practitioner service in any other setting.

A narrative explanation of the service must be submitted with the paper [HFS 2360](#) (pdf) and include: 1) the reason for the prolonged service, i.e., the medical condition(s); 2) exact total time involved; and 3) services rendered during that time period. The amount of time billed should not include time spent performing procedures, and must be only the amount of time the practitioner was involved in face-to-face contact with the participant. If the same practitioner who is billing for prolonged service submits charges for one or more procedures, the narrative must state that the amount of time shown is separate from the time required for the procedure(s).

Procedure: The appropriate CPT code for outpatient or inpatient prolonged service is to be shown for the first 30-60 minutes, the total minutes in the service description field, and a "1" in the Days/Units field. All additional minutes should be shown on the subsequent service line using the appropriate CPT code, the total additional minutes in the Service Description field, and a "1" in the Days/Units field.

A-220.11 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. Newborn care includes history and examination of the infant, daily hospital visits, initiation of diagnostic and treatment programs, preparation of hospital records including hospital discharge summary, discussion(s) with the mother and discharge. Providers must

follow CPT guidelines to designate the appropriate level of initial and subsequent care of a newborn.

The initial examination and routine follow-up hospital care of the newborn child when rendered by the delivering practitioner is considered a part of the delivery service and may not be billed separately. When a different practitioner assumes care of the newborn, that practitioner may submit charges for the initial and/or subsequent hospital care.

A second practitioner may submit charges for attendance at a delivery when required to assume care of the newborn at a cesarean or high-risk vaginal delivery or anticipated high-risk delivery.

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. Consequently, the child's name may not appear on the mother's identification card as an eligible member of the assistance case until a later date. Medical providers may request that a newborn be added to the Medical Assistance case by contacting the local [DHS Family Community Resource Center \(FCRC\)](#) and providing them with the:

- Mother's name and case number.
- Name of the newborn.
- Birth date of the newborn.
- Sex of the newborn.

Charges for **normal newborn care services only**, provided when the name of the eligible child does not appear on the medical card, must be submitted as follows:

Procedure: Use appropriate CPT code for normal newborn care. Complete the claim in accordance with instruction found in Appendix A-1 except for the following fields:

- Patient Name – Enter first name “Baby” and last name “Girl” or “Boy” as appropriate.
 - Date of Birth - Enter the child's birth date.
 - Recipient Identification Number - Enter mother's recipient identification number.
 - Date of Service - Complete the service date box to show the first date newborn care was provided.
-
- Providers must wait to submit claims for care provided to a newborn who develops complications (e.g. jaundice), is transferred to the neonatal intensive care unit, undergoes circumcision, and for any services provided after discharge.

Universal Newborn Hearing Screening

The federally mandated Newborn Hearing Screening required prior to hospital discharge is considered part of the all-inclusive hospital inpatient payment and may not be billed separately.

A-220.12 Neonatal and Pediatric Intensive Care

Neonatal and pediatric critical care CPT codes are age specific by definition. CPT identifies procedures considered to be included in the critical care codes. Separate charges should not be submitted for procedures including, but not limited to, endotracheal intubation, lumbar puncture, vascular punctures, blood gas interpretations, ventilation, surfactant administration, etc.

Payment is allowed for only one (1) critical care visit code per day, per patient for a maximum of twenty (20) days. The initial visit code can only be billed once. Visits made by a second or consulting practitioner must be billed using the appropriate evaluation and management hospital visit CPT codes. The corresponding Critical Care Progress Note or Consultation Report must be attached to the paper [HFS 2360](#) (pdf).

Payment may be made for critical care in excess of twenty (20) days if the billing includes documentation of the medical necessity, i.e., provision of a narrative explanation of the child's condition and the hospital discharge summary. If the child does not meet the criteria defined in the CPT for critical care, bill the appropriate CPT for the level of care provided.

A-220.13 Smoking and Tobacco Use Cessation

Tobacco cessation counseling services for children through age 20 and for women who are pregnant or within the 60-day post-partum period may be a separately billable service. Both counseling and pharmacotherapy are covered without cost sharing.

The Department does not cover tobacco use cessation techniques such as hypnosis, acupuncture, herbal remedies, ear clips, or any other technique that does not conform to a medical model. Use of e-cigarettes is also not recognized or covered for purposes of smoking cessation or harm reduction due to lack of such evidence.

Duration of Counseling

For pregnant and post-partum women age 21 and over, the Department will reimburse up to a maximum of three quit attempts per calendar year, with 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 listed in

the [fee schedule](#). Please note, children through age 20 are not restricted to the maximum twelve counseling sessions.

These counseling sessions must be provided by, or under the supervision of, a physician, or by 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.

The patient's medical record must be properly documented with the provider signature, and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources available and follow-up.

A-220.14 Promoting Healthy Weight

Providers are encouraged to assess and document BMI percentile at least one time per year for pediatric patients' ages 2 through 20 years. BMI assessment may be done during any visit, whether sick child or preventive. Additional information may be found in the Chapter [HK-200 Healthy Kids Handbook](#) (pdf).

Claims for an episode or encounter where BMI is assessed must include the appropriate diagnosis. Providers should append a BMI-related diagnosis code for every episode or encounter of care during which BMI was assessed, documented, and addressed, if indicated.

Documentation must include a note in the patient's record indicating:

- The date on which the BMI percentile was assessed.
- One of the following measurements:
 1. BMI percentile, or
 2. BMI percentile plotted on age-growth chart.
- If indicated, pertinent recommendation or a plan of management consistent with the codes used.

Weight Management Visits: BMI >85th Percentile

Providers may bill for weight management visits for children with a BMI greater than the 85th percentile. The BMI percentile must be measured and documented during that visit.

Visits addressing problem focused care delivered by a physician or an advance practice nurse or physician's assistant billing under a physician may be billed for care delivered and documented using evidence based clinical guidelines.

For children whose BMI is greater than the 85th percentile, payable weight management visits may include a maximum of 3 visits spread over a course of six months; follow up visits after the initial visit must include, in the patient's record, a

note addressing the patient's/parent's readiness to change and outcomes of intervention to date.

The appropriate CPT code and appropriate diagnosis codes must be included on the claim form for each visit.

Diagnosis codes for obesity related co-morbid conditions, if present and addressed at the visit, need to be listed on the claim form for each visit. Each visit should include, in patient record, documentation of educational handouts given, care plan and outcomes based on specific treatment and behavior changes (e.g., nutrition, physical activity, etc.) recommended and made, compliance with past recommendations, results of screening laboratory tests, reports of referrals and consultations if any, and time spent by provider with patient and family during the visit.

No further visits related to weight management will be payable after a maximum of 3 visits over a six month period, unless improvement in BMI percentile is evident based on the diagnosis code submitted on the claim or documentation of favorable outcome is attached to the paper form [HFS 2360 \(pdf\)](#) claim.

Additional Notes on Payment Policies Related to Weight Management

Weight management visits cannot be billed on the same day as a Preventive Medicine visit. Weight management counseling services can be billed as part of a problem focused evaluation and management visit. CPT guidance on this topic allows for this provision when counseling and/or care coordination dominates (more than 50%) face-to-face encounter time with the patient and/or family. The extent of counseling and/or coordination of care (time as well as content of care, coordination and counseling) must be documented in the medical record.

A-221 Anesthesia

Anesthesia services may be provided by an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) and should be reported according to the Anesthesia Guidelines in the CPT. HFS reimburses anesthesia services based on the intraoperative time, anesthesia value of the procedure; and physical status of the participant. Medical or surgical procedures performed outside routine anesthesia care may be billed in accordance with the Department surgical billing guidelines (refer to [Topic A-222](#)). Refer to the Anesthesia Payment Formula (A-13) for additional information.

The anesthesiologist/CRNA may bill the Department for services when not paid by the hospital or other entity as an employee or independent contractor for this service. The Department will not reimburse both an anesthesiologist and a CRNA for the same procedure on the same participant during a single operative session unless supporting documentation is attached to the paper [HFS 2360](#) (pdf) that demonstrates the medical necessity for the services of each.

When anesthesia is personally administered by an anesthesiologist who remains immediately available in the operating area during a surgical procedure, the anesthesiologist may submit charges if the cost of the anesthesiologist's services is not included as an expense item in the hospital reimbursable costs and the hospital submits no charge for the services. If the anesthesiologist is concurrently responsible for the care of more than one anesthetized patient, a claim may be submitted for each patient involved.

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

A-221.1 Preoperative Period

No charges may be made for the preoperative anesthesia consultation. The reimbursement for these services is part of the anesthesia values assigned to each procedure code.

A-221.2 Intraoperative Period

Anesthesia charges are to be submitted only for the time period spent in the operating room, beginning with the anesthesiologist preparing for induction of anesthesia and ending when the patient may be safely placed under postoperative supervision. Unless supporting documentation is required, claims may be submitted electronically or on the paper [HFS 2360](#) (pdf), each with the following billing requirements:

- The date of service billed must be the date the anesthesia service begins.

- The procedure code may be either the major surgical procedure code or the anesthesia CPT code, but anesthesia is only paid for one procedure code per surgical session.
- The physical status modifier (P1 – P6) must be the first modifier on the claim.
- Total time for all anesthesia services provided during the surgical session is to be reported in minutes in the Days/Units field. The Department will convert Medicare crossover claims received directly from the Coordination of Benefits Administrator (COBA) from units to minutes.

When surgical procedures are performed during separate operative sessions on the same service date, separate charges should be shown for anesthesia administered for each operative session with the anesthesia or major surgery CPT code, physical status modifier, and total administration time for each session. The anesthesia record for each operative session must be attached to the paper [HFS 2360](#) (pdf) as documentation that services were provided at different times of the same day.

Refer to Appendix A-13 for the Anesthesia Payment Formula.

A-221.2.1 General Anesthesia

The anesthesiologist/CRNA is to submit one charge totaling the time for all general anesthesia services provided during a single operative session, either the major surgical procedure code or the anesthesia CPT code. Enter the appropriate physical status modifier and the total anesthesia administration time. **Note:** when the general anesthesia administration time billed is 480 minutes or more, the anesthesia record must be submitted with the paper [HFS 2360](#) (pdf).

A-221.2.2 Continuous Epidural Anesthesia

The anesthesiologist/CRNA is to submit one charge for the continuous epidural anesthesia services provided during a single operative session using the appropriate anesthesia CPT code. Enter the appropriate physical status modifier and the total anesthesia administration time. Do not submit the major surgical procedure code.

A-221.2.3 Epidural Anesthesia Followed by General Anesthesia

When epidural anesthesia is followed by general anesthesia on the same date of service during the same operative session, the first charge should be the appropriate epidural anesthesia CPT code with the epidural time in minutes, and the second code should be the appropriate general anesthesia CPT code with the general anesthesia time in minutes. The anesthesia record must be attached to the paper [HFS 2360](#) (pdf) as documentation that both types of anesthesia were administered on the same date.

A-221.2.4 Anesthesia during Labor and Delivery

Payment is not routinely allowed for the administration of general anesthesia for vaginal deliveries. If general anesthesia is required for vaginal delivery, the CPT code for “unlisted procedure, maternity care and delivery” must be used, and a description of the service must be shown in the description field. The operative report or anesthesia record must be attached to the paper [HFS 2360](#) (pdf) as documentation of the service provided.

When epidural anesthesia is started during labor and continued through the vaginal delivery or Cesarean section, use the appropriate CPT code(s).

Note: When the epidural administration time billed for labor and vaginal or cesarean delivery is 1440 minutes or more, the anesthesia record must be submitted with the paper [HFS 2360](#) (pdf).

When epidural anesthesia is started during labor but discontinued and then a general anesthetic is administered for the Cesarean section, two charges should be submitted: the first charge should be the appropriate epidural anesthesia CPT code with the epidural time in minutes, and the second code should be the appropriate general anesthesia CPT code with the general anesthesia time in minutes. The anesthesia record must be attached to the paper [HFS 2360](#) (pdf) as documentation that both types of anesthesia were administered.

A-221.3 Postoperative Period

No charges may be made for routine postoperative follow-up care. The reimbursements for these services are part of the anesthesia value assigned to each procedure code.

Payment is allowed for postoperative pain management only for cases of intractable pain, such as that due to multiple trauma injuries or metastatic cancer. Use the appropriate CPT code as well as the appropriate diagnosis code(s) necessitating the anesthesiologist/CRNA services.

A-221.4 Anesthesia Standby

An anesthesiologist/CRNA may submit a charge for “standby” only when the pre-operative anesthetic examination and evaluation have been performed for a planned surgery but the surgery is canceled due to the participant’s condition. The charge should be submitted using the “unlisted” code for the body system/area related to the scheduled surgery. Enter “standby for surgery cancelled due to [specific reason].” Enter the amount of time required for the standby.

Note: Standby is not allowed for situations where surgery may or may not be necessary, such as an attempted vaginal delivery that may result in Cesarean delivery, etc.

A-222 Surgery

A-222.1 Surgical Services - Office

Certain procedures are eligible for additional reimbursement if the procedure is provided in the practitioner's office. No additional coding is necessary to receive the additional reimbursement. Additional information regarding the surgical add-on may be found on the [Practitioner Fee Schedule](#).

A-222.1.1 Anesthesia

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

A-222.1.2 Dressings

For customary surgical dressings no charges may be made in addition to the office visit or procedure charge. For dressings, that are unusually extensive or required in large amounts, e.g., medicated dressings, charges may be made if substantiating clinical data is submitted with the paper [HFS 2360](#) (pdf).

Procedure: The unlisted office supply CPT code must be billed and the specific item identified in the description field of the paper [HFS 2360](#) (pdf). A copy of the invoice showing the actual cost to the provider must be submitted with the [HFS 2360](#) (pdf).

A-222.1.3 Burn Treatment

Charges may be made for surgical debridement for burns, when substantiating information is submitted. The appropriate CPT code is to be used to submit charges for surgical debridement. Charges must be submitted on the paper [HFS 2360](#) (pdf) with a copy of the notes attached. No additional charge may be made for the evaluation and management CPT code.

A-222.2 Surgical Services - Hospital

A-222.2.1 Covered Surgical Procedures

Surgical procedures are allowable when they are medically necessary, recognized as standard medical care, and required for the immediate health and well-being because of illness, disability, infirmity, or impairment.

The Department may request operative reports as necessary in order to determine payment. The report provided to the Department must be a photocopy of the official operative report on file at the facility. The date of surgery on the operative report must match the service date shown on the claim, and the name of the operating surgeon shown on the operative report must match the name of the billing surgeon.

A-222.2.2 Global Postoperative Period

Charges submitted for a major operative procedure (refer to the [Practitioner Fee Schedule](#) under Surgery Indicator) include the pre-surgical examination subsequent to the decision for surgery and rendered on the date of surgery or the day immediately prior, and complete postoperative care including postoperative office visits and customary wound dressings for a period of 30 days.

Charges submitted for a burn procedure (debridement, skin grafting, and/or flaps, etc.) include postoperative visits, wound care, and dressing changes for a period of seven (7) days after the surgical procedure.

A-222.2.3 Concurrent Care during Postoperative Period

A practitioner other than the surgeon may receive reimbursement during the postoperative period only for visits for conditions/diagnoses unrelated to the surgery. A copy of the progress note must be attached to the paper [HFS 2360](#) (pdf).

A-222.2.4 Multiple/Complex Procedures

When submitting charges for multiple procedures and/or complex surgeries, the practitioner is to attach the operative report to the paper [HFS 2360](#) (pdf). Instructions for billing multiples are specific to the particular procedure code and are included in the [Practitioner Fee Schedule](#).

Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package. Surgical procedures considered incidental to, or a component of, the major procedure will not be paid separately from the major code.

A-222.2.5 Multiple Operative Sessions on the Same Day

When a participant has more than one separate operative session on the same day, the operative reports for all sessions showing the separate operative times must be attached to all subsequent paper [HFS 2360](#) (pdf).

A-222.3 Co-Surgeon/Surgical Assistance

A-222.3.1 Co-Surgeon

When two surgeons of equal competence participate in an operation on a basis of other than surgeon and assistant surgeon, payment is based upon the procedure(s) accomplished and will be divided equally between the two surgeons. Procedure codes payable to co-surgeon are identified on the [Practitioner Fee Schedule](#).

Procedure: Enter the appropriate procedure code(s) for the specific surgical procedure(s) on the paper [HFS 2360](#) (pdf). Each surgeon billing must submit a copy of the operative report. If each surgeon dictates his/her own operative report, both versions must be provided. Enter the Code “2” in Field 23E (T.O.S.) and the co-

surgeon modifier in the modifier field. Enter the following statement in the narrative portion of Field 24C, “Co-surgeon with Dr. (name of co-surgeon).”

A-222.3.2 Surgical Assistance

Surgical assistance is a covered service only when provided for major or complex surgical procedures. Procedure codes payable for surgical assistance are identified on the [Practitioner Fee Schedule](#).

Surgical assistance by an enrolled physician or APN is to submit charges to the Department when serving as an assistant surgeon.

Procedure: Enter the appropriate procedure code for the major surgical procedure. Enter “2” in Field 23E (T.O.S.) to denote that the charge is surgical. Enter the appropriate assistant-at-surgery modifier in the Modifier Field. Complete the “Days/Units” Field of the service section showing the time required to assist at the surgery. Enter the actual time in minute format, e.g., the entry for 1 hour and 10 minutes is “0070.”

Surgical assistance by a physician assistant or a non-enrolled APN

Charges for assistant surgeon services rendered by a physician assistant or a non-enrolled APN must be submitted under the surgeon’s name and NPI.

Procedure: Enter the appropriate procedure code for the major surgical procedure on the paper [HFS 2360](#) (pdf). Enter an “8” in Field 23E (T.O.S.) to denote the charge is as an assistant surgeon. Enter modifier “AS” in the Modifier Field. Complete the “Days/Units” Field of the service section showing the time required to assist at the surgery. Enter the actual time in minute format, e.g., the entry for 1 hour and 10 minutes is “0070.” Enter the name of the non-enrolled APN or physician assistant in the narrative portion of Field 24C.

When the surgical assistance time billed is eight hours or more (480 minutes or more), documentation, e.g., a copy of the operating room record, which shows the time surgery began and ended, must be attached to the paper [HFS 2360](#) (pdf) for reimbursement consideration. The report must specify the amount of time required for the surgery.

A-222.4 Surgical Burn Treatment

Practitioners may submit charges for surgical burn treatment, including debridement, participant site preparation, and application of skin replacements or substitutes (grafting). An evaluation and management visit on the same day as the surgical burn treatment by the same practitioner is not reimbursable.

Claims must be submitted on paper, using the appropriate CPT code for the location and type of wound preparation and application of grafts. Operative reports must be attached to the claim form. The CPT code for the initial procedure is billed with Days/Units showing quantity “1.” The subsequent service section should contain the

CPT add-on code for all additional square cm or percent body area, with the total additional quantity shown in the Description Field, and with the Days/Units Field showing quantity “1.”

A-222.5 Surgery for Morbid Obesity

Surgeries for morbid obesity require prior approval by the Department. Providers must submit requests on the [Form HFS 1409](#) (pdf), Prior Approval Request. Payment for this service may be made only in those cases in which the physician determines that obesity is exogenous in nature, the participant 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.

In addition to the [Form HFS 1409](#) (pdf), providers must submit the following documentation:

- Documentation of review of systems (history and physical) with letter of medical necessity.
- Participant height, weight and BMI.
- Listing of co-morbidities.
- Patient weight loss attempts including participation in six months of a medically supervised weight loss program under guidance of the primary care physician working in conjunction with a registered dietitian within two years prior to the surgery.
- Current and complete psychiatric evaluation indicating the patient is an appropriate candidate for weight loss surgery.
- Documentation of nutritional counseling.

See the HFS website for [instructions](#) (pdf) on completion and submission of form HFS 1409.

Procedure for billing approved surgeries:

- The surgeon is to submit charges for the specific surgical procedure that was prior approved and performed.
- The surgical assistant must submit charges using the unlisted surgical procedure code and the appropriate assistant surgeon modifier in the modifier field. Include in the note loop/description field “assist [surgical code] # # minutes”, and submit quantity “1” in the Days/Units field.
- Anesthesia charges must be submitted in accordance with the guidelines identified in [Topic A-221](#), Anesthesia, using the appropriate anesthesia procedure code.

A-222.6 Organ Transplant

The Department’s Medical Programs provides for payment for organ transplants only when provided by a Certified Transplantation Center as described in [89 Ill. Adm.](#)

[Code 148.82](#) (c) through (g). The practitioner services covered by the payment must be in accordance with the appropriate CPT guidelines. Backbench procedures are not considered separately for reimbursement.

The Department covers non-participant kidney and liver donor procedure charges when not covered by private insurance.

Procedure: Charges are to be submitted under the participant's name and RIN, and must include the donor's name in the description field. Charges must be submitted on the paper [HFS 2360](#) (pdf) with the operative report attached.

A-222.7 Coronary Artery Bypass Graft and Back Surgeries

Prior authorization review is required for elective procedures identified on the current Peer Review Organization (PRO)/ Quality Improvement Organization (QIO) webpage, [Attachment F](#) on the Department's website. The hospital is responsible for notifying the Quality Improvement Organization (QIO) a minimum of three business days up to a maximum of 30 calendar days prior to the planned procedure to request prior authorization review. The QIO will screen for medical necessity of the planned procedure and complete its review within two business days from receipt of all required documentation. The practitioner must provide to the hospital the specific medical information needed for the review. The hospital, as well as the operating practitioner, will receive correspondence from the QIO detailing approval or denial.

If the request is approved, the approval is valid for a 60-day period from the date of the QIO's approval letter. If the surgery cannot be completed within the 60-day timeframe, the patient is admitted to another hospital, or the planned principal procedure code changes, the hospital must submit a request for prior authorization to the QIO for a new approval. If the planned admission date changes to a new date within the original 60-day authorization period, the hospital may update the admit date.

A-223 Family Planning, Pregnancy/Maternity Care and Reproductive Health Care

A-223.1 Family Planning Services

Family planning services are designed to prevent unintended pregnancies, and to improve reproductive health and birth outcomes. Services and supplies that are specifically provided for the purpose of family planning are covered, regardless of gender or marital status. Family planning does not apply to a participant who has been sterilized or is pregnant.

Claims for family planning services should include the appropriate CPT code with Modifier FP (services provided as part of family planning program) and the appropriate diagnosis code that documents the family planning service provided.

The following services are covered without cost sharing for participants in the Department's Medical Programs:

- Medical history and reproductive health exam.
- Preconception care risk assessment.
- Diagnostics (e.g. laboratory, bone scan, ultrasound tests) necessary for the provision of contraception or sterilization.
- Contraception.
 - All FDA-approved methods, including Emergency Contraception,
 - Sterilization procedures (Refer to Topic to A-223.1.4 for consent requirements and billing instructions),
 - Tubal ligation,
 - Vasectomy and
 - Fallopian tube occlusion by placement of permanent implant

A-223.1.1 Preconception Risk Assessment

To receive reimbursement for administering the preconception risk assessment, providers must use the CPT code 99420, Administration and Interpretation of Health Risk Assessment Instrument. Use of HFS' Preconception Screening Check list form [HFS 27](#) (pdf) is the preferred tool; however, other preconception risk assessment tools may be used. Risk assessments must be formally validated, nationally distributed by a recognized organization, and individually administered. The provider must obtain written approval from HFS prior to using other preconception risk assessment tools. Contact HFS' Bureau of Quality Management at 217-557-5438 for questions or to obtain written approval.

A-223.1.2 Diagnostics

See topic A-224 (Radiology) or A-225 (Laboratory) for detailed billing instructions.

A-223.1.3 Contraception

Contraceptive drugs, devices and supplies may be dispensed, prescribed or ordered. Long-acting reversible contraceptives (LARCs) are separately reimbursable from the insertion procedure.

Prescriptions for family planning drugs and supplies may be refilled as prescribed by the practitioner for up to one year. Treatment for sexually transmitted infections (STI), urinary tract infections (UTI), vaginal, other lower genital tract and genital skin infections should be prescribed according to recommended treatment guidelines.

The practitioner may submit charges for the administration or dispensing of contraceptive drugs or supplies purchased using the appropriate HCPCS Code. NDCs, when noted on the Practitioner Fee Schedule as required, should be billed according to Appendix A-8. Providers must dispense the three (3) month supply allowable by the Department whenever possible. Exceptions may be made when medically contraindicated and documented in the patient's chart, or if patient and provider decision making does not require a three month supply to be dispensed.

Procedure: When charges are made for family planning services, the Family Planning Field/Indicator should be completed. The appropriate CPT code(s) should be submitted with modifier FP. Diagnosis coding should document the family planning service provided. For administered or dispensed contraceptive drugs, devices and supplies obtained through the 340B program, charges must be no more than the actual acquisition cost for the product plus the appropriate Department established 340B dispensing fee as noted on the Practitioner Fee Schedule.

Immediate Postpartum LARC Insertion

The Department allows hospitals separate fee-for-service reimbursement for the LARC device 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. Reimbursement for the device is based on the current practitioner fee schedule.

Procedure for hospitals to receive reimbursement for the LARC device:

- A practitioner must order the device from the hospital and document the insertion procedure in the hospital's medical record as well as the practitioner's medical record.
- The hospital must use its fee-for-service NPI to bill the appropriate device.
- The hospital must identify the NDC for the specific device or implant following the guidelines in Appendix A-8.
- The hospital must use the appropriate family planning ICD-10 diagnosis code on this claim.
- The Place of Service code should be designated as Inpatient on the claim.

Practitioners not salaried by the hospital may bill the appropriate CPT code for the LARC insertion in addition to their delivery charges.

Over-The-Counter Emergency Contraception

Emergency Contraception (EC) may be prescribed and/or dispensed to participants in compliance with the FDA regulations for over-the-counter and prescription emergency contraception products.

The Food and Drug Administration (FDA) approved the EC drug, Plan B One Step® (levonorgestrel 1.5mg, one tablet packet) as a non-prescription option for women of childbearing potential. To date, this is the only formulation of over-the-counter (OTC) EC approved by the U.S. FDA without age restrictions. The Department covers this product without a prescription for all women of childbearing potential. The Department will continue to cover other EC products consistent with the FDA approval.

Practitioners who dispense or prescribe EC to participants in the office setting or family planning service clinics authorized by [Title X of the Public Health Service Act, 42 U.S.C. 300, et seq.](#) must record the dispensation or prescription in either the participant's medical record or on a separate dispensing log. The documentation must include the following information: date, dispensing practitioner's name, dispensing practitioner's NPI, participant's name, name of the EC dispensed, quantity dispensed, indication of medical necessity, and the signature of the individual receiving the medication. Such documentation needs to be maintained and retrievable upon request. Department requirements on retention of records as stated in the [Chapter 100 Handbook](#) apply.

Condoms

Over-the-counter condoms may be dispensed to participants without a prescription.

Practitioners who dispense or prescribe condoms to participants in the office setting or family planning service clinics authorized by [Title X of the Public Health Service Act, 42 U.S.C. 300, et seq.](#) must record the dispensation or prescription in either the participant's medical record or on a separate dispensing log. The documentation must include the following information: date, name of person dispensing, participant's name, and quantity dispensed. Such documentation needs to be maintained and retrievable upon request. Department requirements on retention of records as stated in the [Chapter 100 Handbook](#) apply.

A-223.1.4 Sterilization

Sterilization:

- Fallopian tube occlusion by placement of permanent implant.
- Tubal ligation procedures.

- Vasectomy.

Sterilization is a covered service that includes medically necessary follow-up such as semen analysis and hysterosalpingogram (HSG). Sterilization is a covered service only for an individual, male or female, who has given written consent, is at least twenty-one (21) years old at the time consent is obtained, and is not institutionalized or mentally incompetent. At least thirty (30) days, but not more than one hundred eighty (180) days, must have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

In cases of emergency abdominal surgery or premature delivery, the informed consent must have been obtained not less than seventy-two (72) hours prior to the sterilization procedure.

Informed consent may not be obtained while the individual to be sterilized is:

- In labor or childbirth.
- Seeking to obtain or obtaining an abortion, or
- Under the influence of alcohol or other substances that affect the individual's state of awareness.

Written consent to perform sterilization must be obtained on the Sterilization Consent Form [HFS 2189](#) (pdf) (Refer to Appendix A-5). All appropriate sections of the form are to be completed.

Procedure: Use the appropriate CPT code, which describes the procedure performed. See Appendix A-1 for explanation of entry to be made in Field 23C of [HFS 2360](#) (pdf). [HFS 2189](#) (pdf) must be attached to the paper [HFS 2360](#) (pdf), when charges are submitted. Failure to comply will result in denial of payment.

Note: If charges are submitted without the [HFS 2189](#) (pdf), payment for the services will be denied.

As appropriate, copies of the completed consent form are to be made available for the hospital to submit with the UB-04, and to other practitioners who are submitting a claim for services associated with the procedure.

When a tubal ligation is performed following a vaginal delivery or a Cesarean section, payment will be made for the tubal ligation in addition to the delivery.

When the sterilization is performed in a hospital by a salaried hospital staff physician, the signed form [HFS 2189](#) (pdf) is to be attached to the UB-04.

Performance of a procedure that renders a participant sterile, but that was not performed with the intent to sterilize the participant (e.g., removal of a portion of a fallopian tube due to an ectopic pregnancy) must be submitted with the appropriate surgical CPT code and Acute Treatment modifier "AT."

A-223.1.5 Procedure with Visit

Payment for an annual preventive, problem focused E/M visit, or postpartum visit and a long-acting reversible contraceptive (LARC) insertion or removal procedure is allowable when the medical record documents the significant, separately identifiable services and modifier 25 is appended to the E/M service. See below for examples:

- When the provider and patient discuss contraceptive options during an initial or annual preventive visit (99381-99397) or a postpartum visit and subsequently during the same visit, the device is placed, a service code with modifier 25 in addition to the insertion procedure code is reimbursable.
- When the provider and patient discuss contraceptives during a problem focused E/M visit (99201-99215) that was initiated for a reason other than LARC insertion, and on the same date of service the provider places the device, a problem focused E/M service code with modifier 25 in addition to the insertion procedure is reimbursable.
- When the provider and the patient review a previously chosen LARC method and proceed with placement of the LARC, only the insertion procedure code may be submitted.

Providers must use the appropriate Z30 series from the [ICD-10](#), for the primary code attached to the insertion (and/or removal) procedure code.

A-223.2 Reproductive Health Services

The following reproductive health-related services are covered for participants in the Department's Medical Programs:

- Medical history and reproductive health exam.
- Cervical cancer screening, abnormal Pap follow-up (such as repeat Pap tests, colposcopy/biopsy, LEEP, CONE), and HPV vaccination.
- Testing and treatment for STIs found during the family planning exam, and required follow-up.
- Testing and medications for UTI, vaginal, other lower genital tract and genital skin infections found during the family planning exam, and required follow-up.
- HIV testing.
- Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy.
- Hysterectomy.

Reproductive health services should be billed with the appropriate procedure and diagnosis codes for the services provided.

A-223.2.1 Hysterectomy

A hysterectomy is a covered service only when, in the practitioner's professional judgment, it is not performed solely to accomplish sterilization, but is done for other

medical reasons. If there is more than one purpose to the procedure, the practitioner must certify that 1) the hysterectomy is not being performed solely to accomplish sterilization but is being performed for other medically necessary reasons **or** 2) one of the following exceptions. Participant:

- Was already sterile at the time of the hysterectomy
- Had the hysterectomy under a life-threatening emergency situation in which prior acknowledgment of receipt of hysterectomy information was not possible
- Had a hysterectomy performed during a period of retroactive eligibility, and the participant was advised that the operation would render her permanently incapable of reproducing, or the exceptions described above made such an explanation unnecessary or impossible

When the procedure is a covered service, payment for the services provided will be made only when the Department receives a paper [HFS 2360](#) (pdf) accompanied by the signed documentation as evidence that the individual or her representative has been informed orally and in writing prior to the surgery that the procedure will render the individual permanently incapable of reproducing. Written consent to perform a hysterectomy must be obtained on the Acknowledgement of Receipt of Hysterectomy Information, [HFS 1977](#) (pdf). (Refer to Appendix A-4)

Exception: The participant's (or representative's) signature is not required if one of the exception statements on form [HFS 1977](#) (pdf) has been completed by the practitioner.

Procedure: Use the appropriate CPT code, which describes the procedure performed. A copy of the completed [HFS 1977](#) (pdf) must be attached to the paper [HFS 2360](#) (pdf) submitted for the service. For further detail, refer to Appendix A-4.

As appropriate, copies of the completed acknowledgement are to be made available for the hospital to submit with the billing statement, and to other practitioners submitting a billing statement for associated services.

A-223.3 Pregnancy/Maternity Care

Practitioners may submit an evaluation and management CPT or a Category II CPT code for antepartum care for the initial visit to determine pregnancy.

A-223.3.1 Prenatal Care

The appropriate CPT code for the initial prenatal visit is to be reported on the first prenatal encounter with the health care professional providing obstetrical care. Reporting of the last date of menstrual period (LMP) must be reported when billing for the initial prenatal CPT code. For perinatal depression services, refer to the [Handbook for Providers of Healthy Kids Services](#) (pdf) Topic HK203.9.2.

Procedure: Practitioners submitting claims on the paper [HFS 2360](#) (pdf) must report the LMP in Field 14.

Subsequent prenatal office visits are to be billed using the appropriate Category II CPT codes for antepartum care. Practitioners rendering services to women with a diagnosis of pregnancy are not required to bill a participant's private insurance carrier prior to billing the Department. The Department does not reimburse all-inclusive "global" care packages. Charges should be billed for each individual visit immediately to the Department. The Department will collect information regarding paid services and assume responsibility for the collection of the third party benefits.

Note: Providers must choose whether to bill the Department or the private insurance globally. Taking into consideration that once the Department is billed, the provider must accept the Department's payment as payment in full and not bill the private insurance globally.

A-223.3.2 Visits for Medical Complications of Pregnancy

Emergency room or inpatient hospital visits for complications of pregnancy or other diagnosis/conditions related to pregnancy should be billed separately using the appropriate visit codes and not the prenatal visit code. The diagnosis code(s) shown on the claim must be pertinent to the condition(s), which necessitated the hospital visit(s). Providers should bill the day of hospital admission using the appropriate "subsequent" visit code when the admitting practitioner has also been providing prenatal care.

Treatment to Prevent Premature Delivery

The Department provides payment for the following:

- Injection of Alpha Hydroxyprogesterone (17P). The Department will reimburse providers to administer one dose per week during weeks 16 through 36 of the pregnancy. Administering practitioners who purchase the product from a 17P compounding pharmacy may bill the Department for the product, in addition to the administration. 17P should be restricted to pregnant women with a single gestation and a history of prior spontaneous preterm delivery.
- Home uterine monitoring in those cases where the woman has been hospitalized and is being discharged on tocolytic drugs. An all-inclusive daily rate is paid directly to the supplier of the monitoring device.

A-223.3.3 Visits for Medical Conditions not related to Pregnancy

Medical office visits that occur during the prenatal period for conditions other than pregnancy should be billed using the appropriate office visit procedure code for the level of service provided.

A-223.3.4 Delivery

Use the appropriate CPT code for either vaginal delivery or Cesarean Section to bill the delivery. All maternity care services must be billed with separate codes, dates,

and charges. An all-inclusive “global” care package will not be reimbursed. See Topic A-223.3.1.

Payment for delivery includes admission to the hospital, the admission history and physical, management of labor, vaginal or cesarean delivery and post-partum hospital care. Practitioners must bill a participant’s private insurance carrier prior to billing the Department for deliveries.

Procedure for billing multiple births: Enter the appropriate delivery CPT code for the first baby and the unlisted procedure code for all additional babies when billing for multiple births. Enter the description “twin, triplet, etc.” in the description section and a separate charge for each delivery. If one baby is delivered vaginally and the other by Cesarean section, bill the correct code for each with separate charges, and attach both delivery reports.

Note: Payment may also be made for a vaginal delivery that the practitioner performs in the participant’s home. The appropriate vaginal delivery CPT code is to be used and [Place of Service \(POS\)](#) must be home.

Payment is allowed for initiation and/or supervision of internal fetal monitoring during labor only when performed by a consulting practitioner. This service must be billed with a diagnosis code(s), which reflects medical necessity, e.g., high-risk pregnancy.

For information regarding deliveries at Birthing Centers, refer to the [Handbook for Birth Centers \(pdf\)](#).

A-223.3.5 Postpartum

A charge may be submitted for only one (1) six-week postpartum visit per patient, per delivery. Additional visits for postoperative wound checks or outside the six-week postpartum period must be billed with the appropriate evaluation and management CPT code.

A-223.3.6 Delivery Privileges

The Department requires that a practitioner billing for prenatal services have hospital delivery privileges or, if the practitioner does not have such privileges, then the practitioner must have a written agreement with a practitioner or a group of practitioners who do have such privileges and who agree to accept referred participants for delivery and hospital care. The agreement further attest that the referring practitioner will provide participant’s medical records to the admitting practitioner on their mutually agreed upon date of transfer of the participant from the care of the referring practitioner to the care of the admitting practitioner, but no later than thirty-six (36) weeks of the gestational period. A copy of a properly executed agreement must be on file and available for inspection at the office of each of the practitioners involved in the agreement.

The participant must be informed of the arrangements and, if she concurs with the arrangements, she must be informed as to how to access this care and be provided with all relevant information, including the name(s) of the practitioner(s) who have agreed to provide delivery and hospital care.

If a practitioner does not have hospital delivery privileges or does not have an agreement on file with the Department showing that the practitioner has made arrangements for the transfer of obstetrical participants to a practitioner who does have such privileges, the practitioner may not bill the Department for prenatal care.

A-223.3.7 Termination of Pregnancy – Induced Abortions

An induced abortion is the termination of a pregnancy by the performance of a procedure or the administration of a medication. An induced abortion is a covered service only under these conditions:

- The physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother.
- The physician has certified in writing to the Department that the procedure is necessary to preserve the health of the mother.
- The pregnancy is the result of rape.
- The pregnancy is the result of incest.

The Department will reimburse for a surgical abortion or the use of the drug Mifepristone to terminate a pregnancy in the circumstances described above. When billing for an induced abortion covered by the Department, use the appropriate CPT code along with the appropriate “U#” modifier. A listing of the modifiers recognized in processing HFS claims may be found on the [Modifier Listing for Practitioner Claims](#).

When performing a surgical abortion, one all-inclusive charge is to be made for the total service provided.

When a practitioner prescribes Mifepristone to induce an abortion, the Department will reimburse the practitioner for the following:

- A global rate for all three visits required to complete the procedure. The three visits consist of the initial visit, the two-day follow-up and two week follow-up required under the Food and Drug Administration’s protocol for the use of this drug. The practitioner may bill the Department after the first visit. Providers must bill procedure code H0033 along with the appropriate “U” modifier.
- Any necessary tests performed, such as an ultrasound or pregnancy test, billed using the appropriate CPT code.
- Drugs Mifepristone taken at the first visit and Misoprostol taken at the second visit under their respective [HCPCS](#) codes and [NDCs](#).

In the event that the participant does not return for the follow-up visits and seeks treatment from another practitioner, the Department will not require a refund of the global payment made after the first office visit. In this situation, the practitioner

providing the follow-up services should use the appropriate CPT code to bill for the visit.

To receive payment for abortions as described in the preceding paragraphs, a provider must complete the Abortion Payment Application [HFS 2390](#) (pdf). (Refer to appendix A-6). As appropriate, copies of [HFS 2390](#) (pdf) are to be made available to the hospital to submit with the UB-04.

Procedure: Use the appropriate procedure code, which describes the service performed. See Appendix A-1 for explanation of entry to be made in Field 23C of [HFS 2360](#) (pdf). The [HFS 2390](#) (pdf) must be attached to the paper [HFS 2360](#) (pdf), when charges are submitted. Failure to comply will result in denial of payment.

A-224 Radiology Services

Radiological and X-ray services are covered when essential for the diagnosis and treatment of disease or injury. Routine screening X-rays are not covered. **Exception** - mammography, see [Topic A-224.9](#).

Procedure: Charges for the professional or technical component of radiology services must be submitted with the appropriate CPT code and modifier. Additional information regarding billing for radiology services or multiple occurrences of the same procedure on the same date of service may be found on the [Practitioner Fee Schedule Key](#).

Certain X-rays are limited to a quantity of one (1) per day due to the nature of service, e.g., angiography, gallbladder, upper GI series, etc. If the procedure is repeated at a separate time on the same day, the “unlisted” code is to be used with a separate charge and an explanation of the service in the description field of the claim or on an attachment to the claim.

A practitioner may charge only for X-ray examinations provided in the practitioner’s own office, by the practitioner’s staff. When only X-rays are provided at the time of an office visit, an office visit charge may not be made. A central X-ray Department serving the practitioners in group practice is considered the practitioner’s office.

A-224.1 Referral

For necessary X-rays not provided in the practitioner’s office, the practitioner is to refer the participant to 1) the outpatient department of a participating hospital, 2) a radiologist in private practice, or 3) an imaging center. When a referral is made, the practitioner must specify the X-rays ordered. Open-ended request are not allowed. The practitioner may not charge for the act of referring a patient. The actual provider of services is to bill the Department for services. The payment for X-rays includes the provision of a written report to the referring practitioner. The referring practitioner is to file the written report in the participant’s medical record.

A-224.2 Hospital-Based Radiology Services

Hospitals may bill for the technical component only of a referred X-ray service performed using hospital-owned equipment by hospital-salaried ancillary staff. Hospitals should never bill for the professional component of any radiology service.

Only a non-salaried radiologist may bill for the professional component. A hospital-based radiologist may submit charges to the Department for professional services in connection with referred X-ray services if the radiologist’s contractual agreement with the hospital provides for separation of charges and is not included in the cost report for direct patient care. The services must be billed using the hospital-based radiologist’s NPI and not the hospital’s for the professional component. Any interpretations of X-rays or tests not directly related to patient care are not reimbursable.

Hospitals may not bill separately for radiology services when an Ambulatory Procedure Listing (APL) procedure is performed on the same day.

Hospitals may not bill separately for radiology services when the participant is inpatient.

A-224.3 Radiation Therapy

A radiologist may charge only for the specific X-ray examinations or radiation therapy provided in accordance with requests of the referring practitioner. The Department will reimburse for treatment delivery and treatment management. Additional charges for visits or services, such as dosage calculations, port plans, field settings, etc., are not reimbursable. The radiologist is to maintain in the participant's medical record file, the X-ray file, the referral and a copy of the report.

A-224.4 Proton Therapy

Proton therapy is reimbursable to providers having a 'PTN' specialty code on file with the Department. The Department will reimburse for one proton beam treatment delivery code per date of service. In addition, one radiation treatment delivery code is separately payable for the purpose of guidance/localization of the proton beam.

A-224.5 Ultrasound Imaging

Ultrasound imaging, scanning, echograms or sonograms are covered when medically necessary. Routine screening or surveys are not allowed, nor are "rule-out" examinations unless a specific differential problem exists.

When a charge is made for ultrasound examinations, an additional charge cannot be made for radiographic examinations of the same area or systems unless adequate justification is given for both procedures.

Procedure: Charges must be submitted using the appropriate CPT code on the paper [HFS 2360](#) (pdf) with a copy of the justification attached.

A-224.6 Surgical/Diagnostic Procedures Requiring Radiological Supervision/Interpretation

When a radiologist performs a specific procedure, e.g., catheter insertion, biopsy, injection, angioplasty, **and** radiological supervision and interpretation, two separate codes and charges should be submitted. The charges for the procedure and the radiological supervision/interpretation are to be shown on the same claim with Type of Service Code "4, diagnostic X-ray – radiologist."

Note: If the procedure is performed percutaneously and no specific code is available, the practitioner is to use the unlisted code for the pertinent body system

and the specific procedure identified in the description field. Submit documentation with the HFS 2360 form.

Radiologists are not to use incisional procedure codes for procedures done percutaneously.

A-224.7 Computer Tomography (CT) and Magnetic Resonance Imaging (MRI)

Reimbursement may be made to the practitioner for interpretation of CT or MRI procedures provided in any setting. Payment is allowed for only one complete CT or MRI procedure per day per patient (e.g., a CT of the abdomen and pelvis is a complete procedure or multiple sections of the spine).

A-224.8 Multiple Radiology Procedures on the Same Day

Multiple radiology procedures performed on the same day involving areas of the body that the Department considers overlapping are either paid at a reduced rate or rejected as an X-ray procedure previously paid. Submit a paper claim with copies of all radiology reports attached to the paper [HFS 2360](#) (pdf), and payment will be manually determined.

This methodology applies to all radiological testing including X-rays, CT/CTA's, and MRI/MRA's. Examples of overlapping radiological studies include:

- Radiological exam of the pelvis, 1 or 2 views, combined with radiological exam of the hip, complete, minimum 2 views.
- CT of the abdomen and CT of the pelvis, or CT of the head and CT of the neck.
- Any CTA in combination with any CT.
- MRI of multiple levels of the spine.
- Any MRA in combination with any MRI.

The Department will pay separately for an X-ray and a CT of the same area of the body if medically necessary. The Department will pay separately for CT's and MRI's of completely separate areas of the body.

A-224.9 Mammography Screening

Mammography screening is a covered service when ordered by a practitioner for screening by low-dose mammography for the presence of occult breast cancer. Coverage for this service is available under the following guidelines:

- Baseline mammogram for women 35 and older.
- Screening mammogram once per year for women 40 years of age or older.

Note: A mammogram for **diagnostic** purposes is covered, when medically necessary, regardless of sex or age.

For purposes of this policy, “low-dose mammography” means using equipment which is specifically designed for mammography and which meets appropriate radiologic standards for mammography.

A-225 Laboratory

A-225.1 Laboratory Tests

Only those laboratory tests and examinations essential for diagnosis and evaluation of treatment are covered. Batteries of “rule-out” tests are not covered. The appropriate CPT or [HCPCS](#) code is to be used when billing for laboratory tests. The Department has a maximum amount payable for certain panels and chemistries. Refer to [Practitioner Fee Schedule Key](#) and [Lab Rates](#) (pdf).

A-225.1.1 Practitioner Laboratory Billing

A practitioner may charge only for those tests performed in the practitioner’s office by the practitioner’s salaried staff. Payment made by the Department for laboratory tests performed in the practitioner’s office includes both the professional and technical component fees. A practitioner may not charge for laboratory tests when a specimen is obtained but sent out of the office, e.g., skin lesions, pap smears, etc.

A central laboratory, serving practitioners in group practice is considered a practitioner’s office laboratory.

When the participant presents for laboratory tests only, an office visit charge may not be made.

Practitioners providing laboratory services in an office setting must be in compliance with the [Clinical Laboratory Improvements Amendment \(CLIA\) Act](#). For more information regarding laboratory registration, view the [Illinois Department of Public Health](#) website.

A-225.1.2 Ordered or Referred Laboratory Billing

For necessary laboratory tests not provided in the practitioner’s office, the practitioner is to refer the participant to 1) the outpatient department of a participating hospital, 2) a pathologist in private practice, or 3) a Medicare certified independent laboratory.

The practitioner must specify the test ordered when referring to a laboratory not in the practitioner’s office. Blanket, “rule-out”, or open-ended requests are not allowed. The practitioner must use discretion in ordering only those laboratory tests necessary and pertinent to the condition the practitioner is treating. The practitioner must include the participant’s diagnosis or presenting symptoms that indicate the need for the specific tests ordered. The practitioner’s NPI must be available to each laboratory to which referrals are made.

The practitioner may not charge for making a referral, for collection or sending of a specimen for analysis, or for tests ordered, e.g. pap smears (refer to [Topic A-225.2](#)) or blood lead draw (Refer to [Topic A-225.1.8](#)). The actual provider of services is to

submit charges directly to the Department and provide a written report of test results to the practitioner for filing in the participant's medical record.

Note: A charge may be made for a Pap smear only if the laboratory examination is performed in the practitioner's own office laboratory.

A pathologist in private practice may charge for the specific tests and examinations provided; however, an additional office visit charge may not be made. If the pathologist has an office laboratory certified by Medicare as an independent laboratory, independent laboratory policy and procedure apply. Refer to [Chapter L-200](#) (pdf), Handbook for Providers of Laboratory Services, for further information.

A hospital salaried pathologist may submit charges to the Department for professional services in conjunction with referred laboratory services only if the pathologist's contractual agreement with the hospital provides for separation of charges. The claim should be billed using the salaried pathologist's NPI and not the hospital's NPI for the professional component.

Procedure: Charges for the professional or technical component of laboratory services must be submitted with appropriate CPT code and modifier. Additional information regarding billing for laboratory services or multiple occurrences of the same procedure on the same date of service may be found on the [Practitioner Fee Schedule Key](#).

A-225.1.3 Hospital Laboratory Billing

Hospitals may bill for the technical component only when the hospital obtains the specimen and completes the test. The pathologist may bill for the professional component, if the pathologist is not salaried by the hospital. Hospitals should never bill for the professional component only of any laboratory service.

Hospitals may not bill separately for laboratory services when an Ambulatory Procedure Listing (APL) procedure is performed on the same day.

Hospitals may not bill separately for laboratory services when the participant is inpatient.

Hospitals frequently utilize reference laboratories (an off-site laboratory that completes the procedure on the specimen provided to them). If the hospital has a financial agreement with the reference laboratory that the laboratory provides services for the hospital and the hospital reimburses the laboratory for those services, the hospital is entitled to bill the Department for both the professional and technical components rendered at the laboratory for outpatient services. If no such agreement exists, the laboratory may submit charges to the Department. The hospital cannot bill for laboratory services performed by an outside laboratory during an inpatient stay or when there is a billable APL Service.

The Department will only pay an individual service one time. The claim received first will pay. All subsequent claims will be rejected. This also holds true if both a hospital and the reference laboratory bills the same service.

A-225.1.4 Organ or Disease Oriented Panels

CPT codes for panels should be used to report “organ panels”, e.g., Hepatic Function Panel, Thyroid Panel, Arthritis Panel or profiles that combine tests under a problem oriented classification such as Obstetric Profile and Lipid Profile. Providers should not submit charges for individual components of the panel.

A-225.1.5 Chemistries

The Department follows CPT guidelines regarding procedures for billing multiple chemistries. When not all of the tests in the panel are performed, individual test CPT codes are to be used and a separate charge shown for each code. Individual chemistries that are not part of a panel may be billed.

A-225.1.6 Drug Testing

Measurement of one or more drugs in body fluids and/or excreta may be billed under the specific procedure code for the drug(s) test. If no specific drug code exists, the unlisted drug assay CPT code is to be used. When the unlisted code is used, the name of the specific drug(s) tested must be entered in the description field of the paper [HFS 2360](#) (pdf) with a copy of the test reports or a narrative listing of the drug(s) attached.

A-225.1.7 B12 Testing

Payment is allowable for Vitamin B12/Folic Acid testing only when the possibility of Vitamin B12 deficiency is indicated after the presence of macrocytic anemia is detected by a complete blood count. CBC test results must be attached to the paper [HFS 2360](#) (pdf) when charges are submitted for Vitamin B12/Folic acid testing.

A-225.1.8 Blood Lead Screening

The Department will reimburse practitioners for blood lead screening as follows:

- Practitioners enrolled to provide [Healthy Kids services](#) who have requisite equipment may bill for the Clinical Laboratory Improvement Act (CLIA) waived blood lead analysis [ESA Biosciences LeadCare II Blood Lead Testing System (Whole Blood)] using the appropriate CPT code. The venous or capillary blood lead draw is not to be billed separately.
- Practitioners enrolled to provide [Healthy Kids services](#) who send blood lead specimens to the [Illinois Department of Public Health \(IDPH\)](#) laboratory for analysis may bill for venous or capillary blood lead draw using the appropriate CPT code and the [State-specified modifier](#). Laboratory analysis for lead

screening is conducted by the Illinois Department of Public Health and must be mailed to the following address:

Illinois Department of Public Health
Division of Laboratories
825 North Rutledge, P.O. Box 19435
Springfield, IL 62794-9435.

A-225.2 Pap Tests and Prostate-Specific Antigen Tests

Coverage is provided for the following:

- An annual cervical smear or Pap smear test for women.
- An annual digital rectal examination and a prostate-specific antigen (PSA) test upon the recommendation of a practitioner for:
 - Asymptomatic men age 50 and older;
 - African-American men age 40 and older; and
 - Men age 40 and older with a family history of prostate cancer.

Reimbursement for a pelvic exam to obtain the Pap smear or the digital rectal examination is included in payment of the appropriate evaluation and management CPT code. Payment for the Pap or PSA is reimbursable to the performing laboratory.

A-226 Vaccinations (Immunizations)

Vaccinations (immunizations) are covered for children based on schedules established by the [Advisory Committee on Immunization Practices \(ACIP\)](#). Vaccinations are covered for adults when the provider has determined the vaccine to be medically necessary and for preventive purposes (such as influenza and pneumonia vaccines) when administered in accordance with the Center for Disease Control's recommended guidelines. Vaccination information received on claims will automatically be included in the Department's participant immunization record.

Vaccines for children through age 18 years must be obtained from different sources based on a participant's program eligibility. For children through age 18 who are eligible through the Medicaid program, Title XIX (19), all available vaccines should be obtained through the Vaccines for Children (VFC) program, a federally funded, program. Providers are required to enroll in the VFC program to obtain vaccines for the Title XIX (19) eligible children. Providers in the city of Chicago should contact the [Chicago Department of Public Health's VFC program](#). VFC enrollment information for providers located in Illinois outside the city of Chicago is available from the [Illinois Department of Public Health](#) or by telephone at 217-786-7500. Vaccines for children eligible through the Children's Health Insurance Program, Title XXI (21), are not available through the VFC program. Vaccinations for children eligible for Title 21 or through a state-funded program must be obtained through the provider's normal process for obtaining vaccinations. Detailed information regarding the VFC program can be found in the [HK-200](#) Policy and Procedures for Health Care for Children handbook, section 207.2.

Reimbursement will be based on the lesser of charges or the rate posted on the [Practitioner Fee Schedule](#).

- For vaccines available through VFC, the Department will reimburse the administrative cost (practice expense of obtaining the vaccine through VFC) at the lesser of charges or the rate shown in the *Unit Price* column in the Practitioner Fee Schedule. Providers should bill the vaccine code and will be reimbursed for the administration only, or
- For vaccines not available through VFC (including those provided to Title 21 and State-Funded eligible participants through age 18 and participants 19 years of age and older), the Department will reimburse the medically necessary vaccine product at the lesser of charges or the rate shown in the *State Max* column in the Practitioner Fee Schedule. Providers should bill the vaccine code only. The administration is not reimbursable.

Reimbursement for the practice expense of administering injections is included in the office visit when the participant sees a practitioner. If the participant is seen solely for the injection, the CPT code for a minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician may be submitted to cover the injection service expense, and the specific vaccine product procedure code is to be submitted to cover the cost of the vaccine or the cost of obtaining it through VFC. Seasonal flu vaccinations follow these guidelines.

NOTE: Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) providing vaccination services should submit charges as follows:

- With the Clinic visit/encounter, all-inclusive, HCPCS code T1015 when administered during a billable encounter, as defined in [Chapter D-200](#) (pdf), Handbook for Encounter Clinic Services. The detail code(s) must include each specific vaccination given.
- With the Wellness assessment, performed by non-physicians, HCPCS code S5190, when no billable encounter occurs. Detail code(s) must include each specific vaccination given.

The MEDI system and electronic responses (270/271) includes Title XIX and XXI eligibility. The Special Eligibility segment on MEDI will display the specific eligibility information.

A-227 Psychiatry

A-227.1 Individual Psychiatric and Psychotherapy Services

Individual psychiatric and individual psychotherapy services may be covered when personally rendered by an enrolled physician or by an enrolled Advanced Practice Nurse (APN) who holds a current certification in Psychiatric and Mental Health Nursing as set forth in [68 Ill. Adm. Code 1300](#), Appendix A and is practicing in accordance with the Nurse Practice Act.

Services provided by individual licensed psychologists, licensed certified social workers (LCSWs), licensed clinical professional counselors (LCPCs), or licensed marriage and family therapists (LMFTs) are not reimbursable. Psychologist, LCSW, LCPC and LMFT services are only reimbursable when rendered in community mental health centers or Encounter Rate Clinics enrolled to provide those services. Such services must be provided and billed in accordance with guidelines in the applicable handbooks:

- [Service Definition and Reimbursement Guide](#) (pdf) for CMHCs.
- [Handbook for Encounter Rate Clinics](#).

Psychiatric services are covered only when the participant is present for all or some of the service. Psychotherapy times are for face-to-face services with the patient. Psychotherapy of less than 16 minutes duration should not be billed.

Psychiatric diagnostic procedures are stand-alone services and are not to be submitted in combination with evaluation and management service codes, nor may they be submitted on the same day as psychotherapy services. An evaluation and management service may be separately payable with a psychotherapy service.

A psychiatric service may not be billed when the participant receives a psychotropic drug injection and no other service is performed; however, a minimal office visit may be submitted along with an additional charge for the cost of the psychotropic drug when administered in the practitioner's office. See [Topic A-250](#) for policy regarding practitioner administered drugs.

Payment will be allowed for only one psychiatric service to a participant per day when rendered by a physician or APN. This limitation does not apply when psychiatric services are rendered by a physician or APN on the same day that psychotropic medication monitoring is rendered at a Community Mental Health Center.

Electroconvulsive Therapy (ECT) is not considered a psychiatric visit and so is not affected by this service limitation.

In addition to the record requirements in [Topic A-205](#), the participant's record is to show the actual time spent in direct patient care, not including the time required for documenting the record, making reports, etc. If time is not shown on a participant's

record and an audit is conducted, the absence of documentation may result in recoupment of payments based upon the consistency of services rendered versus the time associated with procedures billed.

See [Topic A-220.6.4](#) for policy regarding psychiatric consultations.

A-227.2 Inpatient Care

Basic daily inpatient psychiatric care consists of a therapeutic encounter with the participant and must include one of the following services or an equivalent:

- Medical psychotherapy that may include but is not limited to psychoanalysis; insight oriented therapy; behavior modification; supportive therapy.
- Continuing medical/psychiatric diagnostic evaluation.
- Psychotropic drug management.
- Supervision and management of the patient's treatment program which may include providing guidance and direction to hospital employees involved in the patient's treatment program and/or participation in conferences to plan treatment program.
- Communication with significant others to facilitate patient compliance with hospital treatment and after care.

Other codes for more involved procedures may be used in lieu of basic daily inpatient psychiatric care. In such instances, the participant's record must contain a justification of the use of the more detailed procedure, an indication of the amount of time spent, and a brief description of the service provided.

Length of stay for inpatient hospitalization is controlled by the hospital's utilization review authority.

A-227.3 Group Psychotherapy Services

The following guidelines apply to group psychotherapy delivered in the inpatient hospital, outpatient hospital, encounter rate clinic, and office. The guidelines apply to group psychotherapy rendered to all participants, including those whose primary health care payer is Medicare. These requirements do not apply to services rendered in a community mental health center.

Group psychotherapy services must be rendered by a physician and are limited for each participant to two sessions in a 7-day period, with a maximum of one session per day. The limit of two applies to all group sessions involving the participant, even if billed by different physicians.

Group psychotherapy is not covered for participants who are residents in a facility licensed under the [Nursing Home Care Act \[210 ILCS 45\]](#), including nursing facilities classified as an institution for mental diseases or licensed under the Specialized Mental Health Rehabilitation Act.

Group psychotherapy is not billable by an Advance Practice Nurses (APNs). APN services are covered for group psych only in the FQHC/RHC setting.

A-227.3.1 Psychiatric Certification Requirement

A physician billing for group psychotherapy services must have completed an approved general psychiatry residency program or be providing the service as a resident or attending physician at an accredited residency program. Physicians rendering group psychotherapy and attending physicians submitting claims on behalf of services rendered by a resident must be enrolled through [IMPACT](#).

A-227.3.2 Practitioner Billing for Services Rendered by a Qualifying Resident

Group psychotherapy sessions rendered by a qualifying resident must be submitted with the appropriate group psychotherapy CPT code and modifier GC (service has been performed in part by a resident under the direction of a teaching physician) or GE (service has been performed by a resident without the presence of a teaching physician under the primary care exception).

A-227.3.3 Session Requirements

To be eligible for reimbursement the group psychotherapy session must meet all of the following requirements:

- 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-10](#)) or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Group psychotherapy sessions must be billed with a valid [ICD-10](#) diagnosis within code range F03 through F79.
- Entire group psychotherapy service is directly performed by the billing physician or advanced practice nurse when services are rendered in a FQHC. Services provided by psychologists, social workers, advanced practice nurse, etc. are not reimbursable.
- Group size does not exceed 12 patients, regardless of payment source.
- Minimum duration of a group session is forty-five (45) minutes.
- 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 the begin and end times of each session.
- 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.
- Group session is provided in accordance with a clear written description of goals, methods, and referral criteria.

A-228 End Stage Renal Disease (ESRD) Treatment

Outpatient ESRD treatment services are defined by the Department as renal dialysis treatments and those other outpatient services that are directly associated with the dialysis treatments provided to persons designated by the Department of Health and Human Services as Chronic Renal Patients. These services may be provided by a hospital enrolled for the provision of such services, in or through a freestanding hospital-based dialysis center, in a participant's home, or in an approved "satellite" unit that is professionally associated with the center for the medical direction and supervision. Only the Dialysis Center may submit charges for home dialysis supplies.

Reimbursement for continuing medical management of a maintenance dialysis participant may be made to a practitioner.

The services covered by the payment must be in accordance with Medicare guidelines and billed following the appropriate CPT guidelines. Charges for the insertion of grafts, shunts, de-clotting of shunts, and non-renal physician services are not considered part of dialysis management and must be billed separately. Procedures that are not considered dialysis management are not billable for non-citizen renal dialysis participants.

If an ESRD participant is temporarily transferred to another practitioner for services covered by the monthly payment, charges are not to be submitted by the attending practitioner for the days that the participant is in the transferred status. Each practitioner may only submit charges for the services rendered.

A-228.1 Non-Medicare Eligible Participant

Monthly

The appropriate CPT code for End Stage Renal Disease Related Services is to be used when services are provided during a full month (one procedure code and one charge). **The last day of the month** covered by the monthly payments is to be shown as the date of service. Allow a minimum of 27 days to pass before billing the next month.

Daily

The appropriate CPT code for End Stage Renal Disease Related Services **per day** is to be used when services are not performed consecutively during an entire full month (i.e., patient is a hospital inpatient during the month or services are initiated after the first or the care is transferred to a different practitioner for part of the month). Separate entries, with the appropriate date of service, must be made for each daily charge submitted.

Charges for daily medical management services are not to be submitted for a date of service on which 1) the practitioner has submitted a charge for non-renal services; 2) the patient was under the care of another practitioner (i.e., temporarily transferred);

3) a charge was submitted for services excluded from the monthly payment; or 4) the practitioner has billed as a concurrent care practitioner.

A-228.2 Medicare Eligible Participant

Submit charges to Medicare according to Medicare guidelines. See [Chapter 100 Handbook](#) for additional information regarding Medicare.

A-229 Optometry Services

Practitioners may provide eye care and treatment. Allowable services include:

- Those required to determine the presence of disease and treatment indicated;
- Essential medical and surgical treatment; and
- Prescribing and dispensing eyeglasses and other optical materials. Refer to [Chapter O-200](#), Handbook for Providers of Optometric Services for additional information.

A-229.1 Provision of Eyeglasses and Optical Materials

The provision of glasses and other materials required to restore and conserve vision is a covered service when performed in accordance with the procedures and requirements found in [Chapter O-200 Handbook for Providers of Optometric Services](#).

If the practitioner does not dispense glasses, he/she is to give the necessary prescription to the participant to take to a participating optical provider of the participant's choice.

A-230 Pulmonary Services

Essential pulmonary tests and procedures provided by a practitioner are covered when medically necessary and documented in the participant's medical record.

A-230.1 Pulmonary services with an Office Visit

When pulmonary tests and/or procedures are performed but the practitioner does not see the participant, an office visit charge may not be made.

Visits are not separately payable along with pulmonary services.

Exceptions:

- The evaluation and management is an initial visit, or
- The patient's condition required a significant, separately identifiable service above and beyond the pulmonary service. In such a case, the evaluation and management CPT code with modifier 25 must be submitted on the paper [HFS 2360](#) (pdf) with supporting documentation attached.

A-230.2 Ventilation Management

Ventilation management is a covered service when provided to a participant in the inpatient hospital and nursing home settings.

In accordance with CPT guidelines, the practitioner who is responsible for the ventilation management of a participant may submit charges for either the ventilation management or evaluation and management, but not both on the same day. Another provider may charge for a visit for an unrelated diagnosis.

Ventilation management, initial or subsequent, is not billable by the anesthesiologist for the day anesthesia is administered for surgery. The provision of adequate ventilation to a participant is included in the anesthesia administration fee. When care is rendered in the two days immediately preceding or in the two days immediately following a surgical procedure, by the same practitioner who provides the surgical anesthesia, the services are also considered as part of the anesthesia services related to the surgery and separate charges may not be made for therapy.

A-240 Allergy Services

Allergy sensitivity tests and desensitization services (immunotherapy) provided by a practitioner are covered when medically necessary and documented in the participant's medical record.

A-240.1 Testing

The initial office visit for allergy investigation is considered a comprehensive diagnostic office visit. Appropriate skin tests, sputum and nasal secretion studies, and other essential services are separately billable.

CPT codes listed under Allergy Testing should be submitted for allergy sensitivity tests. The specific number of tests performed should be entered into the days/units field, up to the maximum quantity as specified on the [Practitioner Fee Schedule](#).

A-240.2 Desensitization Injections (Immunotherapy)

The Department will not pay the all-inclusive CPT codes that represent the allergenic extract preparation and provision service as well as the injection service. Separate coding for each service should be submitted. Billing instructions specific to each code may be found on the Practitioner Fee Schedule.

Allergenic extract preparation and provision only:

The practitioner who prepares or supervises preparation of the extract and provides it for the participant should submit charges for the extract. Charges should be submitted for the total number of doses or vials as specified by the CPT code.

Injection service only:

The practitioner who renders the injection service should submit charges for professional services not including provision of allergenic extracts, for single or multiple injections as specified by the CPT code.

Allergenic extract preparation, provision, and injection service

The practitioner who prepares or supervises preparation of the extract and also provides the injection service should submit charges for each service under its separate code. Allergenic extract should only be billed when each new vial of antigen is prepared.

Allergy services with an office visit

Visits are not separately payable along with immunotherapy services.

Exceptions:

- The evaluation and management is an initial visit, or
- The patient's condition required a significant, separately identifiable service above and beyond the immunotherapy service. In such a case the evaluation and management CPT code with modifier 25 must be

submitted on the paper [HFS 2360](#) (pdf) with supporting documentation attached.

A-250 Practitioner Administered Drugs including Chemotherapy

Reimbursement for certain practitioner-administered drugs may be made to practitioners. The drug must have been purchased by the practitioner and must be administered in the office setting in order to be submitted on the professional claim. Medications charged through a pharmacy or facility, except as specified in Section A-202.1.4, Allowable Fee-For Service Charges by Hospitals, are not billable.

Procedure: Submit the appropriate CPT or [HCPCS](#) Code(s) to identify the drug. When a specific code is not available, an unlisted medication CPT code may be used. The corresponding description field must contain the name of the drug, strength of the drug, and amount given. Quantities must be billed according to the Instructions for Billing Multiples located in the [Practitioner Fee Schedule Key](#). The NDC billing instructions located in Appendix A-8 must also be followed.

While coverage for injectable drugs is considered separately from visits or injection administration, the injection procedures themselves (such as tendon or trigger point injections) are considered therapeutic procedures and reimbursement will be made for whichever service the Department prices higher, either the visit or the procedure, as previously described in A-220.2.2, Therapeutic and Diagnostic Procedures Performed During the Office Visit.

Exceptions:

- The evaluation and management is an initial visit.
- The patient's condition required a significant, separately identifiable service above and beyond the therapeutic procedure. In such case, the E&M CPT code with modifier 25 must be submitted on the paper [HFS 2360](#) (pdf) with supporting documentation attached.

A-250.1 Prior Approval Requirements for Practitioner Administered Drugs

The [HCPCS](#) Codes for practitioner-administered drugs that require prior approval are noted on the [Practitioner Fee Schedule](#). Prior approval must be obtained through the Department's Pharmacy Prior Approval Unit. Refer to the pharmacy prior approval procedures outlined in the [Chapter P-200](#), Handbook for Providers of Pharmacy Services, Section 205, Prior Approval Information.

A-250.2 Chemotherapy Services

Chemotherapy services may include provision of chemotherapy administration, chemotherapeutic agents, non-chemotherapeutic drugs, use of supplies, and additional evaluation and management services. Not all services are separately billable.

Chemotherapy Administration: Payment for chemotherapy administration in the office setting may be made to physicians and APNs. Hospitals may bill fee-for-service for the administration of chemotherapy in the hospital outpatient setting.

- The initial hour and subsequent/concurrent time are to be billed according to the CPT guidelines for chemotherapy administration.
- No payment is made for venous or arterial puncture performed for the purpose of administering the chemotherapy.

Drug Charges: Practitioners and hospitals may submit separate charges for the chemotherapy agents and for non-chemotherapy drugs associated with the chemotherapy. The drugs are payable to practitioners in the office setting only. Hospitals may bill fee-for-service for the drugs even if no administration fee is billed. Drugs used in the administration of the chemotherapy should not be billed through the Pharmacy Program.

Chemotherapy Drugs:

- Use the appropriate [HCPCS](#) Codes, indicating the quantity and the corresponding [NDCs](#). Refer to Appendix A-8 for NDC billing instructions.

Non-chemotherapy Drugs:

- Coverage for non-chemotherapy drugs administered for cancer-related treatment or conditions caused by the effects associated with the chemotherapy is reimbursable on chemotherapy or non-chemotherapy days. Claims must contain a chemotherapy diagnosis.
- Use the appropriate [HCPCS](#) Codes, indicating the quantity and the corresponding [NDCs](#).

Chemotherapy Supplies:

Supplies, including fluid used to administer the drugs and to flush infusion ports or lines, are considered incidental according to the CPT guidelines and are not reimbursed separately.

Chemotherapy Services With an Office Visit:

Visits are not separately payable along with chemotherapy administration.

Exceptions:

- The evaluation and management is an initial visit, or
- The patient's condition required a significant, separately identifiable service above and beyond the therapeutic procedure. In such case, the E&M CPT code with modifier 25 must be submitted on the paper HFS 2360 with supporting documentation attached.

A-260 Physical and Occupational Therapy

Outpatient physical rehabilitation (physical, occupational, and speech therapy) services are covered for participants when provided because of illness, disability or infirmity. The practitioner may only charge for an initial therapy treatment personally provided by the practitioner in the practitioner's office and an appropriate evaluation and management CPT code if the therapy treatment is within his or her scope of practice. Additional therapy services are only reimbursed to an enrolled individual therapist or to a fee-for-service hospital billing for a salaried therapist. Outpatient hospital and Individual therapists should refer to [Chapter J-200](#), Handbook for Providers of Therapy Services for additional information.

A-270 Special Services

A-270.1 Conscious (*Moderate*) Sedation

When billing for conscious sedation, the CPT guidelines are to be followed. The same practitioner performing the diagnostic or therapeutic service may bill separately for conscious sedation provided only when the CPT code itself does not include conscious sedation, as listed in the CPT Appendices.

Conscious sedation provided by a second practitioner (other than the practitioner performing the diagnostic or therapeutic service) may be billed when **all** the following conditions are met:

- Services of a second practitioner are required.
- Services are personally rendered by the practitioner billing for the sedation, and
- The practitioner is non-salaried, is enrolled with Medicaid, and is billing under his/her individual NPI.

A-270.2 Unusual Travel

A practitioner may submit charges to the Department for travel if it is medically necessary that the practitioner personally accompanies a participant who is being transported, e.g., by ambulance or air from one hospital to another.

Procedure: Charges must be submitted on the paper [HFS 2360](#) (pdf), using the appropriate CPT code. The practitioner is to provide documentation regarding the:

- Medical necessity for his/her personal attendance.;
- Amount of time required.
- Distance traveled one way.

A-270.3 Mileage

When it is the practitioner's usual and customary practice to charge for mileage to see patients at their places of residence, charges may be made for mileage from the city limits of the town in which the practitioner practices to the place of residence, unless subsequently specified otherwise. Only one mileage charge may be made regardless of the number of participants seen at the time of the home visit.

Procedure: Procedure code 99082 is to be used to identify charges for mileage. The total number of miles one way must be specified in the Days/Units field. The destination, e.g., long term care facility, etc., is to be entered in the facility field.

Practitioners who derive direct or indirect profit from total or partial ownership of where the participant resides may not charge for mileage.

A-270.4 Non-Emergency Participant Transports

The Department reimburses non-emergency transportation providers to transport participants to and from medical appointments if necessary. The services require prior approval. Practitioners may be requested by the Department's prior approval agent to provide documentation regarding a participant's covered medical service or medical condition to determine the appropriate mode of transportation for participants. Information regarding this documentation and the required forms are available on the [Non-Emergency Transportation Services Prior Approval Program's website](#).

Additional information regarding prior approval of non-emergency transportation is available in [Chapter T-200](#), Handbook for Providers of Transportation Services.

A-280 Pharmacy/Medical Equipment/Medical Supplies

When the practitioner determines that an individual has a medical need for a pharmacy item, medical equipment or supplies, a prescription or an order must be written. The individual should obtain the item from a durable medical equipment or pharmacy provider enrolled with the Department. If the item requires prior approval, the dispensing provider will be required to obtain prior approval from the Department before reimbursement can be authorized. Providers will need to submit a medical or prescription order with the prior approval. Refer to [Chapter P-200](#), Handbook for Providers of Pharmacy Services and [Chapter M-200](#), Handbook for Providers of Medical Equipment and Supplies for prior approval requirements.

A-280.1 Medical Equipment and Supplies Dispensed in a Practitioner's Office

The Department does not reimburse for medical supplies (i.e., rubber gloves, colostomy supplies, tracheotomy supplies) dispensed by a practitioner that are not durable or reusable. Coverage is limited to those items that are required following a treatment plan for a specific medical condition. Medical supplies are not to be dispensed or prescribed for a participant's personal convenience.

Exception: Charges may be submitted for items normally available in a practitioner's office (i.e., crutches, wrist splints, air cast, knee brace).

Procedure: The unlisted office supply CPT code must be billed and the specific item must be identified in Field 24C of [HFS 2360](#) (pdf). A copy of the invoice showing the actual cost must be submitted with the [HFS 2360](#) (pdf).

A-280.2 Home Medicine Chest Items

Home medicine chest items may be prescribed only when a participant's need for a specific item is extended or the item is necessary in large quantities for a specific therapeutic reason. Such items include, but are not limited to: throat lozenges, laxatives, petroleum jelly, gauze, adhesive tape, rubbing alcohol, etc.

A-280.3 Prescription Requirements

The Department reimburses for prescription and over-the-counter pharmacy items that are essential for the accepted medical treatment of a participant's symptoms and diagnosis. In order to obtain the pharmacy item, the participant must have a prescription, and the item must be dispensed in accordance with the following requirements and limitations. A prescription is required for both prescription and over-the-counter pharmacy items.

Drug coverage is limited to those products made by drug manufacturers who have signed drug rebate agreements with the federal government. A [listing of rebating manufacturers](#) is distributed quarterly by the Department.

The prescriber must use his or her own prescription form and is responsible for entering the following minimal information on the form:

- Participant's name.
- Date prescription was written.
- Name of pharmacy item being prescribed.
- Dosage form and strength or potency of drug (or size of non-drug item).
- Quantity.
- Directions for use.
- Refill directions.
- Prescriber's NPI.
- Legible signature in ink.

Federal law requires that all non-electronic Medicaid prescriptions be written on [tamper-resistant prescription pads](#). The federal requirement does not apply to electronic prescriptions. An electronic prescription is one that is transmitted from the prescriber to the pharmacy via telephone, telefacsimile, electronic prescribing (e-prescribing) mechanism, or other means of electronic transmission. The Department strongly encourages providers to use an electronic method to transmit prescriptions to pharmacies.

To be considered tamper-resistant, a prescription pad must contain at least one of each of the following one or more industry recognized features designed to prevent:

- Unauthorized copying of a completed or blank form.
- The erasure or modification of information written on the prescription by the prescriber.
- The use of counterfeit prescription forms.

This requirement applies to all prescriptions regardless of whether or not HFS is the primary payer.

Practitioners are to prescribe, and pharmacies are to dispense, medications in quantities reasonably calculated to meet the predictable needs of the participant as long as this does not exceed the designated maximum quantity.

- Patients who are on extended maintenance therapy defined as prolonged use of the same drug, strength, and daily dosage quantity should be issued prescriptions for a 30-day supply per dispensing.
- Providers dispensing birth control (vaginal rings, contraceptive patches, and oral contraceptives) must dispense the three (3) month supply allowable by the Department whenever possible.

The completed prescription form is to be given to the participant to take to the pharmacy of the participant's choice; however, a practitioner may telephone or electronically transmit a prescription, provided that the participant is permitted free choice of pharmacy.

The participant's medical record in the practitioner's office is to contain entries regarding all drugs, medications with dosages, and medical supplies which are prescribed or dispensed, and the participant's response to the treatment. When medications are dispensed to a participant, the practitioner shall comply with all aspects of [Section 33 of the Medical Practice Act](#), particularly those relating to prescription labeling and record keeping.

A-280.4 Non-Covered Pharmacy Items

Prescription pharmacy items that are not covered under the Medical Assistance Program are:

- Drugs manufactured by companies that have not signed a rebate agreement with the federal government.
- Weight loss drugs.
- Agents to promote fertility.
- Agents used for cosmetic purposes, e.g., hair growth or wrinkle-removal.
- Drugs identified by the FDA as being in Drug Efficacy Study Implementation (DESI) status.
- Drugs dispensed after the termination date included on the quarterly drug tape provided by the federal Centers for Medicare and Medicaid Services.
- Drugs indicated only for the treatment of erectile dysfunction.