Billing Nuts and Bolts for SHCs
October 5, 2016

Presented by:
POLICIES:

- Must serve all eligible students, regardless of insurance status or ability to pay
- Billing policies that address Medicaid/Medicare billing must also address billing private insurance, and/or patient, and include a sliding fee schedule
- Billing policies and services must be in accordance with Title V MCH Block Grant requirements
POLICIES:

- Policy for confidential services, which may be billed directly to the patient at patient’s request.
- HIPAA compliant policies address exchange of health information with insurers and managed care entities.
HFS Enrollment and IDPH

Provider Information Sheet –
A copy of all updated HFS Provider Information Sheets must be sent to IDPH (marie.irwin@illinois.gov) when changes are made

**Billing Provider Type 56:**
- The School Health Center is the “Provider” for billing purposes
- Services should be billed according to the Provider’s actual fee schedule, not the HFS schedule reimbursement amount
- Reimbursement amounts are based on the Physicians Fee Schedule

**Billing Provider Type 40 or Type 48**
- Claims should list the appropriate services codes in addition to the “T” code
SHCs must comply with HFS guidelines (as applicable) under:

- Handbook for Providers of School Based/Linked Health Center Services, or
- Handbook for Encounter Based Clinics, and
- Healthy Kids Handbook
Illinois Department of Healthcare and Family Services

School Based Health Services Webinar

October 5, 2016
What’s New at HFS?

- IMPACT Updates
- VFC Program Changes
- Health Alliance Medicare-Medicaid Alignment Initiative (MMAI)
- Care Coordination Health Plan Transitions for ACE and CCE Enrollees
- Managed Care Manual
- Revision of Form HFS 1409 Prior Approval Request and Availability
- Publication of Public Notices on Healthcare and Family Services Website
- Change to Procedure Code for billing Emergency Contraceptive Pills (ECPs)
- Handbook Updates
IMPACT

Enhancement to Allow The Provider to Enter A Remittance Address

- Please refer to the October 28, 2015 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151028a.aspx

- Beginning December 12, 2015 the Enrollment system was modified allowing enrollment of Typical or Atypical Sole Proprietor, Group, Facility/Agency/Organization (FAO) or Atypical Agency with multiple NPI’s (National Provider Identifiers) to enter an optional address termed the Remittance Address

- If a Remittance Address was not entered, then the provider’s payments and remittance advices will be directed to the Pay to Address listed for that TIN

- If a Remittance Address is entered it is important to note there may only be one per IMPACT enrollment no matter the number of locations listed in that enrollment.

- In summary, the IMPACT Remittance Advice modification allowed providers using one TIN, but having multiple NPI’s, to have their own address for the routing of payments and remittance advices

- Providers had previously been informed that the Pay To Address in IMPACT would be used to update all Legacy Payees with the same TIN; however, this did not happen until after January 1, 2016.
Please refer to the IMPACT related provider notices at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx

The Center for Medicare and Medicaid Services (CMS) extended the due date for all Medicaid Providers to revalidate to September 24, 2016

Providers who failed to submit for revalidation by September 24, 2016 will be disenrolled from Illinois Medicaid. Therefore, prior to providing any future Medicaid services and submitting claims, a provider must re-enroll as a new provider into the program. When this occurs, retroactive enrollment requests will not be allowed.

More information on the IMPACT system plus frequently asked questions, webinars and other training guides are available at the IMPACT website: http://www.illinois.gov/hfs/impact/Pages/default.aspx
Please refer to the May 13, 2016 provider notice at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513a.aspx, which reminded providers to select *ALL* correct Specialty/Subspecialty combinations upon completion of the initial application or revalidation in the IMPACT system.

It is important to make the correct selection in order to be reimbursed for all categories of services currently provided to Medicaid participants.

Claims that are submitted with information that is different from the most recent provider information sheet may be delayed in processing or rejected.

Separate applications have been completed by providers for each specialty/subspecialty causing the system to generate additional provider ID numbers resulting in rejections of claims because the system does not recognize them.

A table of IMPACT Provider Types, Specialties and Subspecialties may be found on the IMPACT website, which also provides important information for providers who may have questions regarding these issues.
 Please refer to the May 13, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160513b.aspx regarding the transferring of data from the IMPACT enrollment system into the system that processes provider claims known as the Legacy Medicaid Management Information System (MMIS)

- Provider information sheets are mailed to providers at the office address on file and to all “payee addresses” if different from the office address
- Providers are responsible for reviewing all information for accuracy or risk a delay in claim processing or rejections
- It is critical for payment of claims that the provider name matches the “Doing Business As” name in IMPACT
- Do not change the historical provider name submitted on claims to match the “Doing Business As” name in IMPACT until you have received the provider information sheet from HFS
Please refer to the July 11, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160711a.aspx

Once the revalidation process has been completed, new rendering/servicing providers will be required to enroll in IMPACT whom have not been previously required to enroll as a provider with Illinois Medicaid.

The Department will notify providers when these types of rendering/servicing providers need to begin the enrollment process via a provider notice posted on the IMPACT website.

For additional information, including frequently asked questions, webinars and other training guides, please visit the IMPACT website.
IMPACT
Claims Processing for New and Revalidating Providers

- Please refer to the June 23, 2016 provider notice at:
  [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160623b.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160623b.aspx)

- Although new providers whose enrollment has been approved in IMPACT will receive an email welcoming them as a Medical Assistance Provider, information from the IMPACT enrollment system must be transferred to the legacy system (MMIS) prior to billing. This could take up to two weeks.

- Once the Department has transferred data from the IMPACT system to the legacy system (MMIS), a Provider Information Sheet will be generated and sent to the Pay to Address.

- Prior to billing providers should review the Provider Information Sheet to verify that everything is correct. If correct, claims may then be submitted.

- Providers must request a time override for any claims that are out of timely. **Only claims that could not be billed until enrollment, re-enrollment, addition of a new specialty/sub-specialty, or payee addition was complete are be eligible for time override for 180 days from the update recorded on the provider file.** For instructions on how to request a time override please refer to the Timely Filing Override Submittal instructions found at: [http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx).

- If you have additional questions or need assistance, please contact the IMPACT Help Desk:
  - By email: IMPACT.Help@Illinois.gov
  - By phone: (877) 782-5565 Select option #1
Vaccines For Children (VFC) Program Changes

- Effective October 1, 2016 vaccines obtained through the Vaccines for Children (VFC) program are limited to children age birth through 18 who have Title XIX (19) Medicaid eligibility on the date of service.

- Children with Title XXI (21) - also referred to as CHIP - and State-Funded eligibility must receive private stock vaccines.

- *Reminder*: children with All Kids eligibility may be Title XIX (19), Title XXI (21), or State-funded.

- Providers must verify eligibility on each date of service or risk non-payment or reduced payment.

- Providers may verify participant eligibility and obtain Title information using:
  - MEDI - [www.myhfs.illinois.gov](http://www.myhfs.illinois.gov); see Case Type and Special Information sections.
  - HIPAA 270/271 eligibility request/response.

*Title Information is not available via the Automated Voice Response system (phone system).*
Vaccines For Children (VFC) Program Changes (cont’d)

- Billing process for Practitioners:
  - No change in billing regardless of stock used; claims will systematically edit on eligibility
  - Reimbursement per the Practitioner Fee Schedule:
    - at the *Unit Price* rate when child has Title XIX (19) eligibility
    - at the *State Max* rate when child has Title XXI (21) or state-funded eligibility

- Billing Process for Encounter Clinics:
  - Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Encounter Rate Clinics (ERCs) may bill private stock vaccines fee-for-service (FFS) when the participant is age birth through 18 and has Title XXI (21) or state-funded eligibility
  - Private stock vaccines must be billed with the GB modifier appended to each vaccine-specific procedure code

- Refer to the HFS Non-Institutional Providers Resources webpage at https://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx for detailed vaccine billing instructions, MEDI registration screens and examples of eligibility verification, private stock reimbursement rates, FAQ, VFC program change webinar slides and related provider notices
Prior Approval for Children’s Physical and Occupational Therapy Services (cont’d)

- Children age birth to three may be eligible to receive their physical and/or occupational therapy services through the Illinois Early Intervention (EI) Program, administered by the Department of Human Services.

- Developmental screening should first be conducted by the medical provider at priority intervals at the 9 month and 18 month visit, and the 24 month and/or 30 month visit. Further guidance regarding objective developmental screenings is in Section HK-203.5 of the Handbook for Providers of Healthy Kids Services at:
  

- Screening tools can be found in the appendices in the Handbook for Providers of Healthy Kids Services at:
  
  http://www.illinois.gov/hfs/SiteCollectionDocuments/hk200a.pdf
Health Alliance Medicare-Medicaid Alignment Initiative (MMAI)

- Please refer to the November 29, 2015 provider notice at: [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151029a.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151029a.aspx)

- Health Alliance is no longer be part of the MMAI program effective January 1, 2016. Options for enrollees included enrollment with Molina Healthcare of Illinois by contacting Client Enrollment Services at 877-912-8880 (TTY 866-565-8576) or enrollment in a Medicare Advantage Plan.

- Enrollees who did not opt-in to Molina’s MMAI plan or in a Medicare Advantage plan were automatically enrolled in fee-for-service Medicaid and original Medicare with Part D plan effective January 1, 2016. For more information enrollees should contact Medicare at 800-633-4227, and (TTY 877-468-2048)

*Please note that Health Alliance Connect will continue to be offered to Family Health Plan (FHP) and Integrated Care plan (ICP) enrollees. Only the Health Alliance Connect MMAI plan has terminated.*
ACEs and CCEs have either partnered with existing MCOs, transitioned to become Managed Care Community Networks (MCCNs), or have terminated as an entity. There are no active ACE/CCEs at this time, as all transitions are now complete.

The last ACE transition was completed for September 1, 2016 enrollment effective dates.

Please refer to the January 4, 2016 provider notice for a list of Health Plans that have partnered with the ACE and CCE plans:
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160104a.aspx
Please refer to the January 19, 2016 provider notice at:
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160119a.aspx

A link to the manual is provided in the notice

The manual contains information regarding the Medicaid Managed Care Program and is not intended to supersede, modify or replace any policies, guidelines, or other provider handbooks applicable to providers in the Medical Assistance Program under the fee-for-service payment system.
Revision of Form HFS 1409 Prior Approval Request

- The Department has recently reformatted the HFS 1409 Prior Approval Request Form. There are no changes to the content of the form.

- The new version is available in a PDF-fillable format on the Medical Forms Page at:
  http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx

- The Department will no longer stock a paper version for ordering from the warehouse providers must print off the website version for submission.

- Please refer to the January 26, 2016 provider notice at:
  http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160126a.aspx
Publication of Public Notices on HFS Website

- Please refer to the March 18, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160318b.aspx
- The Centers for Medicare and Medicaid Services (CMS) published final rules designed to ensure that States’ fee-for-service Medicaid payments comply with the access standards outlined in Section 1902(a)(30)(A) of the Social Security Act (SSA)
- This new rule recognizes electronic publications posted on the Medicaid state agency’s web site as an acceptable form of public notice
- The Department has developed a webpage on the HFS web site for the purpose of providing public notice of proposed changes in methods and standards for setting payment rates for services. A link to the public notices can be found under the “Stay Informed” section located at the bottom left hand corner of the HFS Home Page at: http://www.illinois.gov/hfs/Pages/default.aspx
Please refer to the April 29, 2016 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn160429a.aspx

Effective with dates of service June 1, 2016, all emergency contraceptive pills (ECPs) must be billed using procedure code J8499 to allow proper reimbursement to providers.

Effective with dates of service June 1, 2016 the Department will no longer reimburse ECPs billed with procedure code S4993.
Handbook Updates

- Chapter E-200, Audiology Handbook – reissued May 2016
- Chapter B-200, Chiropractor Handbook – reissue COMING SOON
- Chapter L-200, Handbook for Laboratory Services – reissued May 2016
- Chapter F-200, Podiatry Handbook – reissue COMING SOON
- Chapter A-200, Practitioner Handbook – reissue COMING SOON
- Chapter J-200, Therapy Services Handbook – reissued July 2016
- Chapter D-200, Encounter Clinic Handbook – reissued August 2016
  ◦ Will be updated again soon to reflect VFC program/billing changes
Please refer to the June 17, 2015 provider notice concerning the ICD-10 Implementation – Claim Submission Requirements which includes FAQs at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150617a.aspx, with a reminder follow up notice dated October 5, 2015 at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn151005a.aspx

The conversion from ICD-9-CM code set to ICD-10-CM code set as federally mandated was effective October 1, 2015

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

ICD-9-CM diagnosis codes will no longer be accepted on electronic and paper claims with service dates on or after October 1, 2015

The department has revised the following paper claim forms to accommodate ICD-10-CM diagnosis coding which will have a revision date of R-2-15 in the bottom left corner of the form

- HFS 2210 – DME equipment and supplies
- HFS 2211 – Laboratory/Portable X-ray
- HFS 2212 – Health Agency
Family Planning

Dispensing fee for certain 340B purchased birth control methods

- Effective July 1, 2014 the dispensing fee for family planning methods purchased through the 340B federal Drug Pricing Program was increased to $35.00
- Providers must identify 340B purchased drugs by reporting modifier “UD” in conjunction with the appropriate procedure code
- The provider charge should be the actual acquisition cost plus the $35 dispensing fee
- Encounter clinics may bill the device fee-for-service (FFS) separate from any encounter claim the clinic submits for the insertion procedure. If the contraceptive device is not billed separately from the encounter the claim will reject with the HFS proprietary error code G70

Vaginal Ring, Contraceptive Patch and Oral Contraceptives

- 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 medical record
- Please ensure medical records document the reason for NOT dispensing the required three (3) month supply
Senate Bill 741
Medicaid Benefit Changes

- Details may be found on the HFS website at: http://www.illinois.gov/hfs/info/factsfigures/Pages/SB741FactSheet.aspx
- Restoration of coverage for dental care services for adults to that prior to the SMART Act effective July 1, 2014
- Restoration of coverage for podiatry services for adults effective October 1, 2014. Coverage for podiatry services for adults is no longer limited to participants with a primary diagnosis of diabetes.
- Elimination of the prior authorization requirement under the four prescription policy for anti-psychotic drugs effective July 1, 2014
- Elimination of the prior authorization requirement under the four prescription policy for children with complex medical needs who are enrolled in CCE solely to coordinate care for these children, if the CCE has a comprehensive drug reconciliation program, effective July 1, 2014
- Elimination of the annual 20 visit limit for speech, occupational and physical therapies effective October 1, 2014
- Prior approval is required for all participants, occupational and physical therapies effective November 16, 2015
- Speech for children does not require prior approval through the age of 20
Please refer to the August 26, 2014 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140826a.aspx

Tobacco cessation counseling services for eligible participants may be a separately billable service under the following procedure codes:

- 99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
- 99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes

Counseling sessions must be provided by, or under the supervision of, a physician or any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services.
Tobacco Cessation Counseling Services (cont’d)

Duration of Counseling

- For pregnant and up to 60-day post-partum women age 21 and over
  - A maximum of three quit attempts per calendar year
  - Up to four individual face-to-face counseling sessions per quit attempt
  - The 12 maximum counseling sessions include any combination of the two procedure codes identified in the previous slide

- Children through age 20 are not restricted to the maximum twelve counseling sessions
Pharmacotherapy

- The Department covers nicotine replacement therapy in multiple forms, as well as two prescription medications indicated for use as an aid to smoking cessation.

- Please refer to the Drug Prior Approval webpage for specific drug coverage and prior approval requirements. This link may be found at: http://ilpriorauth.com/

- Nicotine replacement duration of therapy is normally limited to three months in a year; however, duration limitations may be overridden by the department through the prior approval process on an individual patient basis.

- To request prior approval for a specific drug please refer to the link at: http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/DrugPriorApprovalInformation.aspx
Annual Medical Cards

- Please refer to the January 30, 2013 provider notice at: http://www.hfs.illinois.gov/assets/013013n.pdf

- Providers should verify medical eligibility at each visit or risk non-payment

- Providers may not charge participants to verify eligibility

- If the individual provides a Medical Card, Participant Identification Number (RIN), or Social Security number and date of birth, providers may verify eligibility through one of the following resources:
  - MEDI Internet site at: http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx
    **when using MEDI be sure to scroll down to view possible MCO enrollment**
  - The REV system. A list of vendors is available at: http://www.illinois.gov/hfs/MedicalProviders/rev/Pages/default.aspx
  - The Automated Voice Response System (AVRS) at 1-800-842-1461
Four Prescription Policy

- HFS has reduced the number of prescriptions that can be filled in a thirty-day period, without prior authorization, to four. Information regarding this policy is posted on the web site at: http://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx

- Exceptions to the prescription policy will be allowed in certain situations, with prior approval. As a reminder, effective July 1, 2014 Senate Bill 741 eliminated the prior authorization requirement anti-psychotic drugs and for children with complex medical needs enrolled in a CCE solely to coordinate their care.

- A prior approval request for exception can be initiated electronically on the MEDI system. Please refer to the September 4, 2012 informational notice entitled Drug Prior Approval/Refill Too Soon Entry System), posted on the web site at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn120904b.aspx

- Effective with the December 10, 2013 provider notice at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131210a.aspx, the Department will not require prior approval or four prescription policy overrides for anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder according to Department records.
Changes to Illinois Hemophilia Program

- Effective with dates of service on or after September 1, 2012, HFS began reimbursing services provided to participants in the Illinois Hemophilia Program at the Department’s standard reimbursement rates.
- As a result, services were no longer reimbursed at the provider’s billed charges.
- The Illinois Hemophilia Program no longer offers additional coverage for primary care physician visits to qualifying participants due to cancellation of the federal waiver program.
- Effective January 1, 2014 a patient’s primary insurance may begin to cover the costs currently covered through the State Hemophilia Program. In accordance with Public Act 98-0104, patients must meet their obligations and may be required to obtain and provide proof of health coverage to the Department. Payment of a tax penalty for not obtaining insurance does not meet the requirement. The Department notified current participants by letter regarding changes. Please refer to the December 27, 2013 provider notice at http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn131227a.aspx for more information and the provider contact number.
Submittal of Claims for Multi-Use Vials

- Please refer to the November 10, 2014 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141110a.aspx

- When billing the Department for a multi-use vial, providers must bill only for the quantity of the drug actually dispensed

- Claims submitted for an entire vial, when a partial vial was used are subject to audit and/or recoupment of any payment made for the unused portion of the medication
Section 340B of the Public Health Service Act limits the cost of covered outpatient drugs to certain federal grantees, FQHC look-alikes, and qualified hospitals. These providers purchase pharmaceuticals at significantly discounted prices. Such providers enrolled with the US Department of Health and Human Resources Administration are considered 340B providers.

Registration for the program is completed through the Office of Pharmacy Affairs, 1-800-628-6297.

Providers enrolled with HFS as a provider type other than pharmacy who are submitting fee-for-service claims for 340B purchased drugs must charge HFS no more than their actual acquisition cost for the drug product.

$12 Dispensing Fee for 340B Purchased Drugs:

- Effective with dates of service on or after February 1, 2013, a $12.00 dispensing fee add-on applies to generic and brand name drugs purchased through the 340B program. Please refer to the April 15, 2013 provider notice at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130415a.aspx, which instructs providers to identify such drugs by modifying the procedure code with the UD modifier and to include the $12.00 dispensing fee in the total charges.

- Reimbursement for 340B purchased drugs will be the lesser of the actual acquisition for the drug, as billed by the provider, or the Department’s established 340B allowable reimbursement rate for the drug, plus the applicable dispensing fee.
180 Day Time Limit for Claim Submittal

- Claim submittals are subject to a filing deadline of 180 days from the date of service.
- *Timely filing applies to both initial and re-submitted claims.*
- Claims submitted greater than 180 days but less than 365 days from the date of service will reject G55/”Submitted later than 180 days, but not more than one year, from date of service”
- Claims submitted greater than 365 days from the date of service will reject D05/”Submitted greater than one year from date of service”
- Medicare crossovers (Medicare payable claims) are subject to a filing deadline of two years from the date of service.
- Please refer to the Non-Institutional Providers Resources webpage at: [http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx) for links to:
  - The Timely Filing Override Submittal Instructions, which includes a list of exceptions to the timely filing deadline and instructions regarding how to request time override
  - The HFS 1624, Override Request form
  - Timely Filing Override Q & A
Co-Pays/Cost Sharing

- Co-pay amounts are *not* reflected on the medical cards.

- Please refer to the March 29, 2013 provider notice at [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130329a.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn130329a.aspx) and Chapter 100, Appendix 12 for the most up-to-date information about co-payment amounts and applicable eligibility categories.

- The Q & A document referenced in the February 14, 2014 provider notice regarding participant liability and co-payments is now available at the Non-Institutional Providers webpage at: [http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx).

- When billing the Department *providers should not report the co-payment*, nor deduct it from their usual and customary charge, on the claim. The Department will automatically deduct the co-payment from the provider’s reimbursement. This applies to direct billing to HFS – please check with the individual plans for guidance on billing for Medicaid managed care enrollees.
Participants excluded from cost sharing include:

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

*Services* exempt from cost sharing include:

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

- Medicaid is nearly always the payer of last resort
- Participants with other insurance/third party liability and Medicaid secondary may be charged the Medicaid co-payment if accepted as a Medicaid patient, but may not be charged the insurance co-payment
- Example:
  - Adult patient, sick visit, has BC/BS with a $20 co-payment, and is enrolled in HFS Family Care Assist with a $3.90 co-payment
  - Provider accepts patient as having Medicaid secondary
  - Provider cannot collect the $20 BC/BS co-payment, but can collect the HFS $3.90 co-payment, even if HFS pays $0.00 because the TPL reimbursement exceeds the state maximum allowed amount
Office Visits

- All Evaluation & Management CPT codes require a face-to-face encounter with the physician/APN/PA. *Exception* - when a participant is seen for a service, such as an injection, and a physician/APN/PA is not required to be present:
  - Practitioner offices may bill the 99211 low-level E/M code
  - Encounter clinics must bill the S5190 Wellness Assessment encounter code and applicable detail code(s)

- When a therapeutic procedure is performed during an office visit, reimbursement will be made for whichever service the Department prices higher, either the visit or the procedure, but not for both unless it is an initial office visit. Encounter clinics should bill both the visit and procedure as detail codes; reimbursement will be at the provider-specific medical encounter rate.

- 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.
EPSDT Codes

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

- Developmental Screening
  - 96110

- Developmental Assessments
  - 96111

- Immunizations (Vaccine billing instructions are located in Chapter 200, Appendix A-9)
  - 90476-90749
EPSDT Codes (cont’d)

- **Lead Screenings**
  - if specimen is sent to IDPH bill 36415/36416 with U1 modifier for the specimen collection
  - if specimen is not being sent to IDPH and is being analyzed at the office bill 83655

- **Hearing Screening**
  - 92551

- **Vision Screening**
  - 99173

- **Labs/X-rays**

- **Mental Health Risk Assessment**
  - 99420

Additional information may be found in the Healthy Kids Handbook (HK-200) & Appendices at:

http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/HK200.aspx
BMI Assessment & Obesity-Related Weight Management Follow-Up for Children & Adolescents

- Please refer to the January 24, 2014 provider notice for details and billing instructions at: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140124c.aspx
- Providers are encouraged to follow recommended clinical guidelines for the evaluation & management of overweight and obesity according to the expert committee recommendations linked in the notice
- Primary care physicians and other providers are encouraged to routinely assess and document children’s weight status at least once per year for patients ages 2 through 20
- BMI assessment may be done during any problem-focused or preventive visit. Claims for an episode where BMI is assessed must include the appropriate CPT and diagnosis codes as referenced in the notice
- Providers may bill for weight management visits for children with BMI >85th percentile as measured and documented according to the notice. Payable weight management visits may include a maximum of 3 visits within 6 months and may not be billed on the same day as a preventive medicine visit.
Prenatal/Perinatal Services

- Prenatal Services
  - 0500F (initial prenatal visit) – date of the last menstrual period (LMP) must be reported when billing the initial prenatal CPT
  - 0502F (subsequent prenatal visit) – routine urinalysis is not separately reimbursable
  - 0503F/59430 (postpartum visit)

- Perinatal Depression Risk Assessment
  - H1000 (screening during a prenatal visit)
  - 99420 with HD modifier (screening during a postpartum visit)
  - Screening during the infant’s visit when the mother is not Medicaid eligible is considered a risk screening for the infant; bill 99420 with HD modifier using the infant’s RIN

- Additional information is available at:
  [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn041130d.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn041130d.aspx)
Newborn Eligibility

- Any child born to a participant is automatically eligible for medical assistance for one (1) year as long as the mother remains eligible for assistance and the child lives with her.

- The mother is not required to submit a formal application for the child to be added to her case.

- Medical providers may request that a newborn be added to the Medical Assistance case by contacting the local DHS Family Community Resource Center. Local site locations can be found at: [www.dhs.state.il.us](http://www.dhs.state.il.us)
Therapy Services

- A practitioner may charge only for an *initial* therapy treatment (prior to referral to a licensed therapist) provided in the practitioner’s office by the practitioner or the practitioner’s salaried staff under the practitioner’s direct supervision.

- This may be billed in addition to the appropriate evaluation and management CPT code.

- Ongoing therapy services are only reimbursed to an enrolled individual therapist.

- Individual therapists and hospitals should refer to Chapter J-200, Handbook for Providers of Therapy Services at [http://www.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf](http://www.illinois.gov/hfs/SiteCollectionDocuments/j200.pdf) and the therapy fee schedule at [http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx](http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/TherapyFeeSchedule.aspx) for information regarding therapy services.
Provider Fee Schedules

- HFS strives to update the Practitioner Fee Schedule quarterly

- The Practitioner Fee Schedule is posted at:
  http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/Pages/default.aspx

- The most recent Practitioner Fee Schedule was posted to the website September 30, 2016 and is effective with dates of service beginning October 1, 2016

- The Practitioner Fee Schedule provides information on coverage, hand-pricing, rates of reimbursement and services that require prior authorization. The fee schedule should be used in conjunction with the fee schedule key, modifier listing, lab panel table, and assistant surgeon rates as applicable. The Practitioner Fee Schedule is useful to encounter rate clinics, as it provides a list of covered services and reimbursement rates for items which may be billed FFS (e.g. LARCs and vaccines administered to children with Title XXI (21) and state-funded eligibility)
Third Party Liability

- Medicaid is nearly always the payer of last resort. All known TPL must be billed before claims may be submitted to HFS. *Exceptions:* services to women with a diagnosis of pregnancy and preventive services for children.
  - Providers are not required to bill a participant’s private insurance carrier for antepartum care services prior to billing the department, however practitioners must bill a participant’s private insurance carrier prior to billing the department for *deliveries*.

- Client-specific TPL appears on the MEDI eligibility detail screen.

- Medicare crossover claims must contain the amount paid by Medicare for each service.

- When a client is identified on the HFS system as having TPL, even if the client or TPL source states the TPL is not in effect, the claim must contain complete TPL information, including:
  - TPL status codes – TPL status codes may be found in the billing instructions for paper claim preparation in the appendices of all Chapter 200 Provider Handbooks.
  - Payment amounts.
  - TPL date - instructions may be found in the billing instructions for paper claim preparation in the appendices of all Chapter 200 Provider Handbooks.

**For discrepancies between TPL reported by participants and TPL information reported in MEDI please contact the TPL unit at 217-524-2490.**
HFS Paper Claim Forms

**Please refer to instructions in the appendices for details regarding required, conditionally required, and optional fields**

- HFS 2360 – Instructions may be found in Chapter A-200, Appendix A-1:
  - Physicians
  - APNs
- HFS 2360 – Instructions may be found in Chapter D-200, Appendix D-1:
  - Encounter clinics

  **The HFS 2360 must be used when Medicare is primary but denies the service**

- HFS 3797 – Instructions may be found in Chapter 200, Appendix A-2:
  - All providers billing Medicare crossovers (when there is a Medicare allowed amount, even if applied to deductible)
The Chapter 300 Companion Guide for 5010 may be viewed at:
http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

5010 submissions sent by a Clearinghouse or uploaded via batch to the MEDI system will receive a 999 Functional Acknowledgement

- Please note: A second 999 Functional Acknowledgment is possible as additional audit checks are completed. A second 999 always indicates rejection of the file(s).

**Providers are responsible for verifying that HFS has accepted all submitted files**
Medical Electronic Data Interchange (MEDI)

- MEDI is available for:
  - Verifying client eligibility
  - Submitting claims
  - Submitting replacement claims (bill type ‘7’)
  - Submitting voids (bill type ‘8’)
  - Downloading the 835 Electronic Remittance Advice
  - Checking claim status

  **PLEASE NOTE: HFS BILLING CONSULTANTS DO NOT CHECK CLAIM STATUS**

- Login and access requires a State of Illinois Digital Identity

- For new users:
  - Obtaining a State of Illinois Digital ID is a one-time process
  - Requires entry of Illinois-based information from Driver’s License/State Identification Card
  - Registration must match the provider’s information sheet

- There are two types of USER registration in the MEDI System:
  - Administrator (required - limit of 2)
  - Employees (no limit)
ANSI 835 (Electronic Remittance Advice) is in Production

The 835 is available to the designated payee

HFS error codes are not included on the 835. Codes provided on the 835 are national reason and remark codes which can be found at: http://www.wpc-edi.com/reference.

Providers should refer to the subsequent paper remittance advice for additional information regarding claim rejections.
Once the Illinois Digital Identity registration is complete, login to: [http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx)

For technical assistance with the following please contact 217-524-3814:
- Authentication error (non-password)
- Upload batch
- 835 (ERA) and 999 (FA) assistance

For technical assistance with the following please contact 1-800-814-3648:
- registration
- digital certificate/password reset
- administrator/biller authorization
Voids & Replacement Claims

Voids

• May be completed on paper by using the HFS 2292 NIPs Adjustment Form. The Department will no longer stock a paper version for ordering from the warehouse. Providers must use the PDF-fillable format available at the ‘Medical Forms Alphabetical Listing’ or ‘Medical Forms Numeric Listing’ link on the Medical Forms page at: http://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx.

• The instructions for completion of the HFS 2292 may be found in Appendix 6 of the Chapter 100 handbook at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx

• May be completed electronically by using bill type ‘8’ to void a single service line or entire claim

Replacement Claims

• completed electronically by using bill type ‘7’ to void a single service line or entire claim

The instructions for electronic voids and replacement claims may be found in the Chapter 300 Companion Guide at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

Please Note: voids and replacement claims require the 17-digit DCN from the original, paid claim. Using the 12-digit DCN from the paper remit:

• Add ‘201’ to the beginning of that 12-digit number

• Add either the 2-digit section number to void or replace a single service line, or ‘00’ to void or replace an entire claim, to the end of that 12-digit number
Referring/Ordering Practitioner

- In the future, referring/ordering and prescribing practitioners will be required to be enrolled with Medicaid

- Providers will be notified via provider notice prior to implementation
National Correct Coding Initiative (NCCI)

- Medicaid is required to enforce the NCCI edits that Medicare has used for several years
- HFS continues to review updates to these edits as they are published and implement payment policy changes accordingly
COMMON BILLING ERRORS

- C02 – additional information required
- C03 – illogical quantity
- C17 – place of service illogical
- C97 – no payable service on claim (encounter claims only)
- D01 – duplicate claim – previously paid
- D05 – submitted greater than one year from date of service
- G11 – IHC PCP referral required
- G39 – client in MCO – Integrated care program
- R36 – client has Medicare – bill Medicare first
- X05 – Hospital visit disallowed
- X06 – surgical package previously paid
- H50 – payee not valid for provider
- M93 – missing payee/multiple payees
- H55 – rendering NPI missing/invalid
- G55 – submitted later than 180 days, but not more than one year, from date of service
- T21 -- Client has Third Party Liability

Chap. 100 Handbook, Appendix 5 details HFS remittance advice error codes at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx
Contact Numbers for Billing Questions or Prior Approval

Main Number : 877-782-5565

PLEASE NOTE......

- HFS Medical Programs has recently implemented a new phone system and menu options have changed. Additionally, menu options will change again in the near future.

- Claim status is not available by phone. Claim status is available using MEDI, the 835 ERA, and the paper remittance advice.
HFS Home Page: http://www.illinois.gov/hfs/Pages/default.aspx
Laws and Rules: http://www.illinois.gov/hfs/info/legal/Pages/default.aspx
Handbooks, including appendices:
http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx
  • Chapter 100 – General Policy and Procedures
  • Chapter 200 – Provider Handbooks by provider type
  • Chapter 300 – Handbook for Electronic Processing
Medicaid Fee Schedules:
https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx
Non-Institutional Providers Resources webpage:
https://www.illinois.gov/hfs/MedicalProviders/NonInstitutional/Pages/default.aspx
Provider Releases and E-Mail Notification for Releases:
http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx
Thank You!

- Please send any feedback on the webinar to:
  - Kristen Nuyen, EverThrive Illinois
    - Phone: 312-491-8161 x 25; Email: knuyen@everthriveil.org

- Questions for IDPH can be directed to:
  - Jill Sproat, Office of Women’s Health/School Health, IDPH
    - Phone: 217-782-0555; Email: Jill.Sproat@Illinois.gov

- Questions for HFS on billing can be directed to:
  - Provider Billing Hotline
    - Phone: 877-782-5565