Chapter A-200

Practitioner Services

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Foreword

Purpose

This handbook has been prepared for the information and guidance of practitioners who provide items or services to participants in the department’s Medical Programs. It also provides information on the department’s requirements for provider participation and enrollment.

The Practitioner Handbook can be viewed on the department’s Web site. This handbook provides information regarding specific policies and procedures relating to medical services rendered by practitioners.

It is important that both the provider of service 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 in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the department’s Medical Programs. The updates will be posted to the department’s Web site on the Provider Releases and Bulletins page.

Providers will be held responsible for compliance with all policy and procedures contained herein. Providers wishing to receive e-mail notification, when new provider information has been posted by the department, may register on the Web site.

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

**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, Illinois Cares Rx (ICRx), Veterans Care, and Health Benefits for Workers with Disabilities (HBWD)

**Document Control Number (DCN)** – A twelve-digit number assigned by the department to identify each claim that is submitted by a provider. The format is YDDDLLSSSSSS.
- **Y** Last digit of year claim was received
- **DDD** Julian date claim was received
- **LL** Document Control Line Number
- **SSSSSS** Sequential Number

**Fee-for-Service** – A payment methodology in which reimbursement is considered for each service provided

**HCPCS** – Healthcare Common Procedure Coding System

**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

**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 who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago) All Kids, FamilyCare,
Illinois Cares Rx (ICRx), Illinois Healthy Women, 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).

**Practitioner** – For purposes of this handbook, a practitioner is a health care professional or entity who is rendering medical services and is enrolled with HFS as one of the following provider types (physician, advanced practice nurse, imaging center, 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** – The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

**Provider Participation Unit (PPU)** – 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 on billings for services rendered.

**Remittance Advice** – A document issued by the department which reports the status of claims (invoices) and adjustments processed. May also be 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.

**Telespsychiatry** – 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.
A-200 Basic Provisions

For consideration for payment by the department for medical services, a provider enrolled for participation in the department’s Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in 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 are specific to the department’s paper forms. Providers wishing to submit X12 or NCPDP electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 identifies information that is 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 Participation

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 reimbursable costs. 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 reimbursement costs, are not approved for participation unless their contractual arrangement with the hospital enables them to submit their own charges for professional services and they do bill private patients and collect and retain payments made.
- Hospitalists may be approved for participation.
- 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 treatment services.

It is required that each physician must enroll with the department in order to be considered for participation and reimbursement.

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); and
- 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 who are authorized to practice in a hospital 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.

**Procedure:** The practitioner must complete and submit:

- **Form HFS 2243** (pdf) (Provider Enrollment/Application Form)
- **Form HFS 1413** (pdf) (Agreement for Participation)
- **Form HFS 1513** (pdf) (Enrollment Disclosure Statement)
- **Form HFS 2307** (pdf) (Hospital, Professional School or Group Practice as Alternate Payee), if applicable
- **Form HFS 2306** (pdf) (Power of Attorney), if applicable
- **Form HFS 3441A** (pdf) (MCH Primary Care Provider Agreement), if applicable
- **Form HFS 3882** (pdf) (Psychiatric Residency Certification) and a copy of the accredited residency completion certificate or a letter from the residency program verifying completion, if appropriate
- **Form HFS 3411C** (pdf) (Advanced Practice Nurse (APN) Certification and Collaborative Agreement Form) and a copy of certification in Psychiatric and Mental Health Nursing, if appropriate
- **W9** (Request for Taxpayer Identification Number)

These forms may be obtained from the department's [Web site](#) or by [E-mail](#).

Providers may also call the Provider Participation Unit at 217-782-0538 or mail a request to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date.

**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.

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 enrollees primary and preventive services, including well child visits, immunizations, screening, and follow-up care as needed. The PCP will also make referrals to specialist 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 will be paid monthly, even if the enrollee does not utilize a service that month. PCPs are to bill their usual and customary rate for the given service 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. In addition, in Illinois Health Connect, PCPs are provided with access to quality tools to assist them in improving the quality of care for their enrollees.

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 (PT 52)
- School-Based/Linked Clinics
- In certain instances, nurse practitioners, midwives and physician’s assistants that 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 Web site 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 who are 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
• 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

To participate in the MCH Program, the provider must sign the HFS 3441A (pdf), in addition to being enrolled as a Medical Assistance provider.

A-201.5 Participation Approval

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data carried on department computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix A-12. 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-201.6.

A-201.6 Participation Denial

When participation 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 participation 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 carried 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 are to be corrected and the department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the department is to be notified. When possible, notification should be made in advance of a change.

**Procedure:** The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the department of 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 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 paid for services, all claims, including claims that are re-billed, must be received within one (1) year of the date of service. The department must receive a claim after disposition by Medicare, or its fiscal intermediary, no later than twenty-four (24) months from the date of service.

A practitioner may charge only for services personally provided, or which are provided under direct supervision in the practitioner’s offices by ancillary licensed or certified staff, e.g., laboratory tests done by a technician in the practitioner’s employ.

A practitioner may not charge for services provided outside the practitioner’s office by anyone other than the practitioner.

Exception: 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 1305)
- 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 physician is allowed to bill for a service provided by another physician when the second physician is “substituting” for the attending physician. This provision is to cover situations in which the attending physician is ill, on vacation, or because of an emergency situation. The substitute physician 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 physician 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 time limitations are 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 physician should bill the department, showing the provider 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 physician 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 physician.

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

**A-202.11 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. 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 is personally involved by having 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-202.12 Allowable Charges by Hospital Salaried Practitioners**

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 the HFS 2360 (pdf) under the physician’s name and NPI. Hospitals may submit charges on the UB-04 for the APL procedure.

Salaried practitioners may not submit charges for services provided to patients who are receiving inpatient care.

=A-202.13 Allowable Fee-For-Service Charges by Hospitals
Effective Date: June 15, 2011

Hospitals may submit fee-for-service charges for the following services performed in the hospital outpatient setting at the hospital’s main campus or in a hospital-owned off-site clinic within 35 miles of the main hospital campus:

- Administration of chemotherapy for the treatment of cancer
- Administration and supply of the following injectable medications
  - Chemotherapy agents for the treatment of cancer
  - Non-chemotherapy drugs administered for conditions associated with the chemotherapy and submitted with the cancer-related diagnosis
  - Baclofen
  - Lupron
  - RhoGAM
  - Synagis
  - Tysabri
- Reference (outside) laboratory services
- Outpatient laboratory and radiology services ordered by a physician
- Durable Medical Equipment and Supplies
- Speech and occupational therapy

A-202.14 Services Provided by Interns and Residents

When an intern or 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 intern’s or 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’s protocol.
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-202.15 Allowable Charges for Services Provided at a Hospital-Owned Off-Site
Facility
Effective Date: June 15, 2011

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, Topic H-270. Services that fall within the limits of
Topic A-202.13 of this handbook and do not contain a billable APL service 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-202.12. Other professional services
such as office visits must be billed by the practitioner who rendered the service. If
billing electronically, indicate the rendering practitioner in the Rendering Provider
Loop.

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.
Refer to Appendix A-15, for billing examples.

A-202.2 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 Chapter 100, Topic 112.3 or Chapter 300, Topic 302.
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. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data.

A-202.3 Claim Preparation and Submittal

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions on preparing claims for Medicare covered services, refer to Appendix A-2.

The department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendices A-1 through A-5 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scanability/imaging evaluation. 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: Provider/Image System Liaison

A-202.4 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.

Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.
For participants eligible for Medicare Part B benefits, payment will be considered on the deductible and coinsurance amounts and/or for department’s Medical Programs covered services not covered by Medicare. (See Chapter 100, Topic 120).

A-202.5 Fee Schedule

The fee schedule of allowable Procedure Codes and special billing information is available on the department’s Web site. The Web site listings and the downloadable rate file are updated quarterly.
A-203  Covered Services

A covered service is a service for which payment can be made by the department. 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.

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. Refer to Chapter 100, Topic 103, for a general list of covered services.

A-203.1  Out of Area Referrals

A practitioner should only refer a participant to a participating source of medical care, if the care and service for which referral is made are medically necessary and 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-204  Non-Covered Services

Services for which medical necessity is not clearly established are not covered in the department’s Medical Programs. See Chapter 100, Topic 104 for 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 or in-vitro
- Abortion, except in accordance with HFS Rule 140.413 (a) (1)
- Medical or surgical transsexual treatment services
- Subsequent treatment for venereal diseases when such services are available free of charge through State and/or local health agencies
- Dietitian counseling
A-205  Record Requirements

See Chapter 100, Topic 110, for record requirements applicable to all providers. 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 Chapter 100, Topic 110 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 Illinois Health Connect PCP Referrals

Illinois Health Connect requires its participants to be seen by their own PCP or a physician 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 that 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.

A-220.21 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.

A-220.22 Therapeutic Procedure Performed During the Office Visit

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 visit.

A-220.23 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-220.24 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-220.3 Outpatient Services

A-220.31 Referred Services

A practitioner may refer participants for essential services such as laboratory tests, X-ray examinations, etc., which 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-220.32 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 must be “11”, Office. Charges are to be made for procedures as indicated for Evaluation and Management Services, Topic A-220.

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-220.51 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 one attending/admitting practitioner will be paid 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-220.81, 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-220.52 Utilization Review

The medical need for hospital admission and the length of hospitalization are monitored and controlled by the 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 may use Severity of Illness/Intensity of Service (SI/IS) or other 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 does require prepayment review 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.

Prior to seeking reimbursement of the hospital stay, the QIO is responsible for certifying that the participant’s care was medically necessary and met established acute inpatient criteria.

A-220.6 Consultations

A consultation is the 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 consultation service is considered the entire package of practitioner services required 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-220.61 Second Surgical Opinion

Payment is allowed for a second surgical opinion consultation when it is medically necessary.

A-220.62 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-220.63 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 this case, the practitioner must submit the appropriate evaluation and management CPT Code for the level of service provided.

A-220.64 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-220.65 Consultation within a Day of Surgery

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

- A consult is payable separately from the surgery if the procedure is performed for a traumatic event. A traumatic event is defined here as an emergency admission, complications of an emergency nature, or traumatic conditions such as acute appendicitis or fractured hip, or
- A consultation by the operating surgeon, that results in a decision for surgery and is performed within a day of the consult, is separately payable from the surgery if it is not performed solely for the purpose of completing the preoperative history and physical and when 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-220.66 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-220.67 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.

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

Telehealth services include telemedicine as well as telepsychiatry. Under the department’s telehealth policy, providers will be paid as either an Originating Site or Distant Site. Refer to Appendix A-9 for billing examples.

**A-220.67.1 Originating Site (Patient Site)**

The Originating Site is the location where the participant receiving the telehealth service is located. Originating Site providers may receive reimbursement for a facility fee for each telehealth service. Providers eligible to receive a facility fee are physician’s office, podiatrist’s office, local health departments, community mental health centers and outpatient hospitals. In order to receive reimbursement for the facility fee, Originating Site providers must bill HCPCS Code Q3014 (Telehealth originating site facility fee).

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 IL Admin Code 132.25, must be present at all times with the patient at the Originating Site.

**A-220.67.2 Distant Site (Provider Site)**

The Distant Site is the site where the provider rendering the telehealth service is located. Providers rendering telemedicine and telepsychiatry services at the Distant Site shall be reimbursed 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.

Nonenrolled 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 have an HFS 3882 on file with the department. Claims received from Distant Site providers who do not have an HFS 3882 on file with the department will be rejected.

A-220.7 Emergency Services

Emergency services are those services which are 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 goes to the 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 received will be for the service with the higher reimbursement rate.

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

When the physician 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 physician must bill using his/her name and NPI.

Under no circumstances may both the physician and the hospital bill the physician’s service.

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: Practitioners 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 hospital discharge summary. 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.

When the same practitioner performs a procedure or procedures other than those, which are included in the visit, and sees the participant in the critical/intensive care unit, payment will be made for the procedure or the visit, but not both. The allowable service is the one with the higher State maximum allowable fee.

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.

The critical care visit includes the interpretation of diagnostic tests as listed in the CPT. Separate payment is not allowed for these services. Refer to the CPT for services included in critical care visits.

A-220.81 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 Hospital Discharge Summary) 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 “1” in Field 23E (T.O.S.) and the appropriate CPT Code in Field 24C. A copy of both the consultation report and the Hospital Discharge Summary 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 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-220.91 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-220.92 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-220.93 Noncovered 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 the practitioner’s office.

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 and the total minutes should be shown in the service description field. All additional minutes should be shown with a second charge and the appropriate CPT Code for outpatient or inpatient prolonged services. The time must again be specified in the service description field.

**Note:** Do not bill for each 30 minutes with a separate charge, as the same code cannot be billed more than once for the same date, same participant. Do not use the days/units field to show the time.

**Example:** A total of 3 ½ hours for prolonged practitioner service is to be billed with one charge and the appropriate code for the first hour. A second charge is to be billed using the Procedure Code for all additional minutes but with the charge being for all of the remaining 2 ½ hours. The minutes must be shown in the service description field and “1” in the quantity field.

**A-220.11 Newborn Care**

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.

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

Practitioners may receive reimbursement for subsequent hospital care and discharge for a newborn.

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 following information:

- The mother's name and case number
- The name of the newborn
- The birth date of the newborn
- The 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 “Baby Girl” or “Baby 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

**A-220.12 Neonatal Intensive Care**

Neonatal critical care CPT Codes apply to infants ages zero (0) through twenty-eight (28) days. Pediatric critical care CPT Codes apply to children twenty-nine (29) days through twenty-four (24) months. The CPT identifies procedures, which are 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 Consultation Report and Hospital Discharge Summary 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-221 Anesthesia

Anesthesia services may be provided by the anesthesiologist or the CRNA and should be reported according to the Anesthesia Guidelines in the CPT. Procedures performed outside routine anesthesia care may be billed in accordance with the department surgical billing guidelines, refer to Topic A-222.

Anesthesia time must be reported in minutes. The department will convert Medicare crossover claims received directly from the COBC from unit to minutes. Refer to Appendix A-7 for anesthesia pricing 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 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

The date of service billed must be the date the service begins. Time reporting guidelines are outlined in the CPT. Time is to be reported in minutes in the Days/Units field. The appropriate Type of Service and/or Taxonomy Code is to be used. 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.
A-221.21 General Anesthesia

When billing for general anesthesia, the anesthesiologist/CRNA is to submit one charge totaling all procedures done during a single operative session, either the major surgical Procedure Code or the anesthesia CPT Code. Enter the appropriate physical status modifier (P1-P6 which are identified in the CPT or Practitioner Fee Schedule) in the modifier field. Enter the total anesthesia administration time to account for all procedures performed during the operative session, in the days/units field. **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-221.22 Continuous Epidural Anesthesia

When billing for continuous epidural anesthesia, the anesthesiologist/CRNA is to submit one charge for all procedures done during a single operative session using the appropriate anesthesia CPT Code. When only epidural anesthesia is administered, do not submit the major surgical Procedure Code. Enter the appropriate physical status modifier (P1-P6 which are identified in the CPT or Practitioner Fee Schedule) in the modifier field. Enter the total anesthesia administration time to account for all procedures performed during the operative session, including line placement, in the days/units field.

A-221.23 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-221.24 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. 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 during vaginal deliver 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, charges should be submitted as instructed in *Epidural Anesthesia Followed by General Anesthesia*. The anesthesia record must be attached to the paper [HFS 2360](https://www.hrsa.gov) as documentation that both types of anesthesia were administered on the same date.

### A-221.3 Postoperative Period

No charges may be made for routine postoperative follow-up care. The reimbursement for these services is 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 designated 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-222.11 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-222.12 Dressings

For customary surgical dressings no charges may be made in addition to the office visit or procedure charge. For dressings, which 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 must be submitted with the HFS 2360 (pdf).

A-222.13 Burn Treatment

Charges may be made for surgical debridement for burns, when substantiating information is submitted. No additional charge may be made for the evaluation and management CPT Code.

Procedure: 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.

A-222.2 Surgical Services - Hospital

A-222.21 Covered 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 exactly match the name of the billing surgeon.

A-222.22 Global Postoperative Period

Charges submitted for a major operative procedure (as displayed on 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-222.23 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 hospital discharge summary must be attached to the paper HFS 2360 (pdf).

A-222.24 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. 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-222.25 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-222.31 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-222.32 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.

If the presence of a surgical assistant is required by hospital bylaws on other than major surgical procedure, reimbursement for such service will be considered only if a photocopy of the hospital’s bylaws accompanies the bill.

Payment is made for only one surgical assistant. The physician or APN who serves as the assistant surgeon is to submit charges to the department.

**Procedure:** Enter the appropriate Procedure Code for the major surgical procedure. Enter the Code “2” in Field 23E (T.O.S.) to denote that the charge is as an Assistant Surgeon. Enter the appropriate Assistant 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.”

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. Enter the Code "8" in Field 23E (T.O.S.) to denote that 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 narrative signed by the physician verifying the amount of time is also acceptable.
A-222.4 Surgical Burn Treatment

Practitioners may submit charges for surgical burn treatment, including debridement, recipient 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 CPT Code appropriate 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

Payment for this service may be made only in those cases in which the physician determines that obesity is exogenous in nature, the recipient has had the benefit of other therapy with no success, endocrine disorders have been ruled out, and the body mass index (BMI) is 40 or higher, or 35 to 39.9 with serious medical complications.

The medical record must contain the following documentation of medical necessity:

- Documentation of review of systems (history and physical);
- Client height, weight and BMI;
- Listing of co-morbidities;
- Patient weight loss attempts;
- Current and complete psychiatric evaluation indicating the patient is an appropriate candidate for weight loss surgery;
- Documentation of nutritional counseling.

Procedure: The surgeon submits charges for the specific surgical procedure performed. The surgical assistant must submit charges using the unlisted surgical Procedure Code and the appropriate assistant modifier in the modifier field. Complete the "Days/Units" Field of the service section showing the time required to assist at the surgery. Anesthesia billing must be submitted using the appropriate anesthesia Procedure Code and in accordance with the guidelines identified in Topic A-221, Anesthesia.

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 Illinois Administrative Code 148.82 (c) through (h). 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 donor procedure charges when not covered by private insurance.

**Procedure:** Charges are to be submitted under the participant’s name and number 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-223  Family Planning and Reproductive Health Care

A-223.1 Family Planning Services
Revised: Effective January 1, 2012

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

The following services are covered for participants in the Department’s Medical Programs, including those women with Illinois Healthy Women (IHW) coverage only:

- Medical history and reproductive health exam
- Contraception – all FDA-approved methods, including Emergency Contraception
- Sterilization procedures – tubal ligation, vasectomy and implants (Refer to Topic A-223.6 for consent requirements and billing instructions)
- Laboratory tests necessary for contraception
- Screening mammogram ordered during a family planning visit (Refer to Topic A-224.8 for screening mammogram guidelines)

Contraceptive drugs and supplies may be dispensed, prescribed or ordered. 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

Procedure: When charges are made for family planning services, the Family Planning Field should be completed. The appropriate evaluation and management CPT Code should be submitted with modifier FP. Diagnosis coding should document the family planning service provided, as shown in the V25 series from the ICD-9-CM.

The practitioner may also submit charges for the administration or dispensing of contraceptive drugs or supplies they purchased using the appropriate HCPCS Code. NDCs, when noted on the Practitioner Fee Schedule as required, should be billed according to Appendix A-6.

Sterilization:
- Fallopian tube occlusion by placement of permanent implant
- Tubal ligation procedures
- Vasectomy

Refer to Topic A-223.6 for consent requirements and billing instructions.

Procedure for Fallopian Tube Inserts: The appropriate HCPCS Code must be billed on the paper HFS 2360 (pdf). Form HFS 2189 (pdf) must be attached when charges are submitted. Failure to comply will result in denial of payment.
Practitioners must submit charges for the implant procedure and the post-procedure confirmation test using the appropriate CPT Code.

**Mammograms:** Only screening mammograms (not performed for diagnostic purposes) ordered during a family planning visit are considered to be a family planning service.

= **Over-The-Counter Emergency Contraception**  
*Revised: Effective April 2, 2012*

Over-the-counter Emergency Contraception (EC) may be dispensed to participants aged 17 and older without a prescription. EC requires a prescription for participants aged 16 and younger.

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 ordered, 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 Chapter 100, Topic 110 apply.

=A-223.2 Reproductive Health Services  
*Revised: Effective January 1, 2012*

The following family planning related services are covered for participants in the Department’s Medical Programs, including those women with Illinois Healthy Women (IHW) coverage only:
- 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.

Reproductive health services should be billed with the appropriate diagnosis code for the service provided. Provider should refer to the IHW Web site for IHW approved lists of service codes and drugs/supplies covered under IHW.

**Noncovered services under IHW:**
- Diagnostic testing, follow-up diagnosis and/or treatment for an abnormal mammogram are not covered under the IHW Program. Patients should be
referred to the Illinois Breast and Cervical Cancer Program (IBCCP). Contact the Women’s Health-Line at 1-888-522-1282 (TTY: 1-800-547-0466) for more information.

- Additional follow-up for abnormal Paps that are not covered by the IHW program, should be referred to IBCCP. Contact the Women’s Health-Line at 1-888-522-1282 (TTY: 1-800-547-0466) for more information.

=A-223.3 Preconception Risk Assessment
Revised: Effective January 1, 2012

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 Risk Assessment and Clinical Guidance Tool (Form HFS 27), found on the HFS Medical Programs Forms Web page, 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 Maternal and Child Health Promotion at 217-557-5438 for questions or to obtain written approval.

Preconception risk assessment is not covered for participants with IHW coverage only.

A-223.4 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-223.41 Prenatal Care

The appropriate CPT Code for initial prenatal visits 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.

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 Code for ante partum care. Practitioners providing services to women with a diagnosis of pregnancy are not required to bill a participant’s private insurance carrier prior to billing the department. Charges may be billed immediately to the department. The department will collect information regarding paid services and assume responsibility for the collection of the third party benefits.
A-223.42 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. The diagnosis code(s) shown on the claim must be pertinent to the condition(s), which necessitated the hospital visit(s). Bill the day of admission to the hospital under 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 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-223.43 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-223.44 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.

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.

**A-223.45 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-223.5 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-223.6 Sterilization**

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. Procedures performed, which render a participant sterile, not performed with the intent to sterilize the participant, e.g., ectopic pregnancy must be submitted with the appropriate surgical CPT Code and modifier “AT.” 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 HFS 2189 (pdf) (Refer to Appendix A-4). 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, 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 HFS 2189 (pdf) is to be attached to the UB-04.

**A-223.7 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:
- The participant was already sterile at the time of the hysterectomy.
- The participant had the hysterectomy under a life-threatening emergency situation in which prior acknowledgment of receipt of hysterectomy information was not possible.
- The participant 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 sterilization must be obtained on the HFS 1977 (pdf). (Refer to Appendix A-3)

Exception: The participant's (or representative's) signature is not required if one of the exception statements on the 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. (Refer to Appendix A-3.)

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

A-223.8 Termination of Pregnancy – Induced Abortions

An induced abortion is a covered service only when, in the professional judgment of a licensed practitioner, a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death, or if the pregnancy is the result of rape or incest, or to protect the woman's health.

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 HFS 2390 (pdf). (Refer to appendix A-5). 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. For an exception regarding mammography, see Topic A-224.8.

Procedure: Charges for the professional or technical component of radiology services must be submitted with 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 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

A hospital based radiologist may submit charges to the department for professional services in connection with referred X-ray services only if the radiologist’s contractual agreement with the hospital provides for separation of charges and the hospital does not bill for the professional component. Any interpretations of X-rays or tests, which are not directly related to patient care, are not reimbursable.

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 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-224.5 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.

Radiologists are not to use incisional Procedure Codes for procedures done percutaneously.

**A-224.6 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-224.7 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. A rejected claim may be resubmitted with copies of all radiology reports attached, 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-224.8 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:

- A baseline mammogram for women 35 and older:
- A 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, which are 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 dollar amount payable for certain panels and chemistries. Refer to Practitioner Fee Schedule Key.

A-225.11 Practitioner Laboratory Billing

A practitioner may charge only for those tests performed in the practitioner’s office by the practitioner’s 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, permits and/or full licensure, contact:

Illinois Department of Public Health
Division of Health Care Facilities and Programs
525 West Jefferson Street, Fourth Floor
Springfield, Illinois  62761

A-225.12 Ordered or Referred Laboratory Billing

For necessary laboratory tests not provided in the practitioner’s office, the practitioner is to refer 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, which the practitioner is treating. The practitioner is to 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 A225.2) or blood lead draw (Refer to Topic A-225.18). 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](https://example.com), 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 and the hospital does not bill 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](https://example.com).

**A-225.13 Hospital Laboratory Billing**

Hospitals may bill global for laboratory services in the outpatient setting when the hospital obtains the specimen, completes the test and issues the report.

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 only for the professional component 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 an 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 the services for the hospital and the hospital reimburses the laboratory for those services the hospital is entitled to bill the department for the services rendered at the laboratory. If no such agreement exists, the laboratory may submit charges to the
department. The hospital cannot bill for laboratory services done 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. If the hospital bills global and a pathologist bills professional, the claim received first will pay. All subsequent claims will be rejected. This also holds true if the hospital bills and the reference laboratory bills also.

A-225.14 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. Do not submit charges for individual components of the panel.

A-225.15 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 not part of a panel may be billed.

A-225.16 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-225.17 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 when charges are submitted for Vitamin B12/Folic acid testing.

A-225.18 Blood Lead Screening

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

- Practitioners enrolled to provide healthy kids services who have the 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 reimbursable.
• 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 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 the 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 the schedule established by the Advisory Committee on Immunization Practices (ACIP) and as described in the Chapter HK-200, Handbook for Providers of Healthy Kids Services. 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.

Providers should enroll in the Vaccines for Children (VFC) program, a federally funded, state operated program. The Illinois VFC Program provides state purchased vaccine for HFS eligible children through the age of 18 years at no charge to the public or to private providers. Additional information regarding VFC may be viewed in the Chapter HK-200, Topic HK-207.2.

Payment will be made for the specific vaccine according to the examples for children and adults in Appendix A-8 of this handbook. Reimbursement will be based on the lesser of charges or the rate posted in the State Max column on the Practitioner Fee Schedule. Specific notes are applicable to each vaccine code and are explained in the Fee Schedule Key. Reimbursement for the practice expense of administering the injection is included in the office visit when the client sees a practitioner. If the client comes in 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 practice expense, and the specific vaccine 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.

**Exception:** Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) may submit charges for vaccinations only when they are administered during a billable encounter, as defined in the Chapter D-200, Handbook for Encounter Clinic Services. The detail for the specific vaccination defined by the CPT Code must be reported.

Refer to Appendix A-8 for billing examples.
A-227  Psychiatry

A-227.1  Psychiatric Services

Psychiatric services are not covered services for participants of Transitional Assistance or Child and Family Assistance (Category 07).

Exception: Children 17 years of age or younger are eligible to receive the full range of covered services of the department's Medical Programs.

The physician or APN who is submitting the charges must provide psychiatric therapies. Services provided by a psychologist, social worker, etc, are not reimbursable.

Exception: When a participant receives a psychotropic drug injection only at the time of an office visit; it is considered a minimal office visit.

Procedure: The CPT Code for a minimal office visit is to be used when submitting charges for the psychotropic drug injection only. An additional charge may be made for the cost of the psychotropic drug given.

Payment will be allowed for only one psychiatric service per day.

Exception: Payment will be allowed for two (2) psychiatric services when one of the services is Electroconvulsive Therapy (ECT).

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-220.64 for policy regarding psychiatric consultations

A-227.2  Inpatient Care

Basic daily inpatient care consists of a therapeutic encounter with the patient 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

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

The group psychotherapy requirements apply to services rendered to participants with Medicare as their primary insurance. These requirements do not apply to services rendered in an FQHC or a community mental health center.

A-227.31 Psychiatric Certification Requirement

Effective with dates of service January 1, 2010, and after, any physician billing 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 planning to render group psychotherapy and attending physicians submitting claims on behalf of services rendered by a resident must have an HFS 3882 (pdf), Psychiatric Residency Certification and a copy of the accredited residency completion certificate or a letter from the residency program verifying completion on file with the department.

A-227.32 Resident Billing Requirements

Group psychotherapy sessions rendered by a 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-227.33 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-9-CM) or the Diagnostic and Statistical Manual of
Mental Disorders (DSM IV). Group psychotherapy sessions must be billed with a valid ICD-9-CM diagnosis within code range 290 through 319.

- Entire group psychotherapy service is directly performed by the billing physician. 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; and
- For participants who are residents of a long term care facility, the provider of the group psychotherapy must maintain documentation in the patient's medical record demonstrating the coordination of services and the sharing of information related to the patient's needs and the implementation and effectiveness of the patient's plan of care with the long term facility.
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.

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 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 physician has submitted a charge for non-renal services; 2) the patient was under the care of another physician (i.e., temporarily transferred); 3) a charge was submitted for services excluded from the monthly payment; or 4) the physician has billed as a concurrent care physician.
A-228.2 Medicare Eligible Participant

Submit charges to Medicare according to Medicare guidelines. See Chapter 100, Topic 120, for additional information regarding Medicare.
A-229  Optometry Services

Practitioners may provide eye care and treatment. Services, which may be provided, 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. All lenses and frames are to be obtained from the Department of Corrections (DOC) laboratory. The department will reimburse DOC for the lenses and frames.

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.

The practitioner is to dispense and prescribe in accordance with the procedures and requirements found in the Chapter O-200, Handbook for Providers of Optometric Services.
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.

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

When a significant separately identifiable evaluation and management service by the same physician on the same day of the pulmonary service is performed, the evaluation and management CPT Code with modifier 25 must be submitted on the paper HFS 2360 (pdf) with supporting documentation attached.

A-230.1  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 may submit charges. A subsequent hospital visit (evaluation and management CPT Codes) is not allowed the same day as ventilation management to the same provider. Another provider may charge for a visit for an unrelated diagnosis. Charges may be made, however, for daily visits as appropriate.

**Procedure:** Use the appropriate CPT Code for the initiation of pressure or volume preset ventilators for assisted or controlled breathing first day and subsequent days. Enter a “1” or “2” in Field 23E (T.O.S.) on the HFS 2360 (pdf).

Ventilation management, initial or subsequent, is not allowed when billed 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 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. Payment for an office visit at the same time is only payable, when a significant separately identifiable evaluation and management service by the same practitioner on the same day the immunotherapy service is performed.

**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. The total number of doses or vials as specified by the CPT Code should be identified in the description field, the quantity “1” should be entered in the days/units field, and supporting documentation must be attached to the paper HFS 2360 (pdf).

**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.

**With an office visit**
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 A-202.14, Allowable Fee-For Service Charges by Hospitals, are not billable.

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. In addition, NDC billing instructions located in Appendix A-6 must 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-220.22, Therapeutic Procedure Performed During the Office Visit.

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

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. In addition to the chemotherapy administration, the practitioner may submit charges for the initial office visit only.

Practitioners and hospitals may submit separate charges for the chemotherapy agents and for non-chemotherapy injectable 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. Supplies, including fluid used to administer the drugs, are considered incidental according to the CPT guidelines and are not reimbursed separately.
Chemotherapy Administration:
- The initial hour and subsequent/concurrent time are to be billed according to the CPT guidelines for chemotherapy administration.
- Separate payment is allowed for an initial visit the day of chemotherapy administration; however, follow-up visits are included in the chemotherapy administration fee.
- No payment is made for venous or arterial puncture performed for the purpose of administering the chemotherapy.

Chemotherapy Drugs:
- Use the appropriate HCPCS Codes, indicating the quantity and the corresponding NDC(s). Refer to Appendix A-6 for NDC billing instructions.

Non-chemotherapy Injectable Drugs:
- Coverage for non-chemotherapy injectable drugs may include antiemetics, antihistamines, and an injection administered for the treatment of chemotherapy-induced anemia and/or leukopenia and is reimbursable on chemotherapy or non-chemotherapy days. Claims must contain a chemotherapy diagnosis.
- Payment for office visits due to chemotherapy complications are reimbursable to practitioners in the office and are not reimbursable in the hospital outpatient setting.
- Use the appropriate HCPCS Codes, indicating the quantity and the corresponding NDC(s).
A-260  Physical and Occupational Therapy

The practitioner may charge 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, in addition to the appropriate evaluation and management CPT Code. Ongoing therapy services are only reimbursed to an enrolled individual therapist. 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.
- The practitioner is non-salaried, enrolled with Medicaid, and billing under his/her individual NPI.

A-270.2 Unusual Travel

A practitioner may submit charges to the department for travel if 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 1) the medical necessity for his/her personal attendance; 2) the amount of time required; and 3) the 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 place 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 may not charge for mileage.

A-270.4 Non-Emergency Participant Transports

Practitioners may be requested by the department's prior approval agent to provide documentation regarding a participant’s covered medical service, medical condition or the appropriate mode of transportation for participants requesting assistance with
transportation to their medical appointments. Information regarding this documentation and the required forms are available on the Non-Emergency Transportation Services Prior Approval Program’s Web site.

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 may be written. The individual may 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. 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 characteristics:

1) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank form;
2) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3) One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

This requirement applies to all prescriptions regardless of whether HFS is the primary or secondary 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. The exception to this policy is for birth control pills for which up to a 90 day supply may be dispensed.

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 pharmacy to prescribe, 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 Exceptions

Limitations apply for participants 18 years and older eligible for the Child and Family Assistance Program or for the Transitional Assistance Program, Category 07.

Note: Children ages 17 or younger, in Child and Family Assistance cases, in the City of Chicago are eligible to receive the full scope of department’s Medical Programs covered services.

A-280.5 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.

A-280.6 Group Care Restricted Items

Certain items provided to residents of skilled and intermediate care long term care (LTC) facilities are the responsibility of the facility. Pharmacies cannot bill the department for these items when provided to participants living in these facilities. The pharmacy is responsible for ensuring that it does not bill the department for these items when dispensed to residents of these facilities.

Additionally, Long Term Care (LTC) facilities are required to provide durable medical equipment and supply items, including wound care dressings, to participants as a part of the per diem reimbursement paid to the facilities by the department. In addition, certain drug items are considered the responsibility of the LTC facility as a part of their per diem reimbursement. Those drug items are:

- Acetaminophen
- Aspirin
- Milk of Magnesia
- Multivitamins
- Zinc Oxide Ointment
• Over-the-Counter drugs, prescribed by the participant’s health care provider, which are not covered under the department’s Medical Assistance Program.

Drugs considered palliative in nature, or related to the illness for which a patient is receiving hospice care, are the responsibility of the hospice. These drugs should be billed to the hospice.