Handbook for Providers of Therapy Services

Chapter J-200
Policy and Procedures For Therapy Services

Illinois Department of Healthcare and Family Services

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Chapter J-200

Therapy Services

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Foreword

Purpose

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

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

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

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

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

Acronyms and Definitions

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

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

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

Early Intervention (EI): Illinois' Early Intervention program's mission is to assure that families who have infants and toddlers, birth to three years of age, with diagnosed disabilities, development delays or substantial risk of significant delays, receive resources and support that assist them in maximizing their infants' and toddlers' development. EI services must be sought first for children in this age group.

Providers billing for EI covered items or services must bill the EI Central Billing Office (CBO) for payment. Contact Early Intervention at 1-800-634-8540 for service questions, and 217-782-1981 for billing questions.

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

HCPCS: Healthcare Common Procedure Coding System

HFS 1443 (pdf): The Department of Healthcare and Family Services Provider invoice

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.

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

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

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

Practitioner: For purposes of this handbook, a practitioner is a health care professional or entity 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 Enrollment Services (PES): The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

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

Chapter J-200

Therapy Services

J-200 Basic Provisions

For consideration of payment by the Department for therapy services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Services provided must be in full compliance with applicable federal and State laws, the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms and apply to patients enrolled in traditional fee-for-service and **do not apply to patients** enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Further information can be found at the HFS Care Coordination website.

Providers submitting X12 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.

J-201 Provider Enrollment

J-201.1 Enrollment Requirements

The Department enrolls individual therapists, as well as hospitals billing for salaried therapists in the outpatient hospital on-site setting, and hospitals billing for salaried therapists in off-site clinics that are within a 35-mile radius of the main hospital campus.

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

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

Refer to the IMPACT Provider Types, Specialties and Subspecialties document for additional information.

Therapy service providers must meet one of the following criteria to be considered for enrollment to participate in the Department's Medical Programs:

- A physical therapist who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice
- An occupational therapist who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice
- A speech-language pathologist (SLP) who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for licensure (i.e., individuals in their Clinical Fellowship Year (CFY) with a temporary license)

Please note: Although therapists do not bill the Department for durable medical equipment (DME), the Early Intervention Program requires therapists to enroll for the DME subspecialty. However, only enrolled DME providers can bill the Department for equipment.

J-201.2 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data on the Department's 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 J-4.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic J-201.4.

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

J-201.3 Enrollment Denial

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

Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of enrollment are in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are in 89 Ill. Adm. Code 104 Subpart C.

J-201.4 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 via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

Department Responsibility

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

J-202 Reimbursement

A claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer must be reflected as a credit on any claim submitted to the Department for those services. Therapy services are not subject to the Department's co-payment policy.

Please note, it is the provider's responsibility to verify claims are received by the Department, whether submitted electronically or on paper, and to check claim status.

J-202.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. **Providers may only bill the Department after the service has been provided.**

An enrolled therapist may only charge for services he or she personally provides, or for services provided by a licensed therapy assistant under the supervision of the enrolled therapist. Speech-language pathologists may also charge for services provided by individuals in their Clinical Fellowship Year. Hospitals may bill for salaried therapists using the hospital's fee-for-service NPI. Providers may not charge for services provided by another provider, even though one may be in the employ of the other. Services must be billed in accordance with the Therapy Providers Fee Schedule.

Charges for services and items provided to participants enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs) must be billed according to the provider's contractual agreement with those entities. Medicaid covers those items or services during the time that the participant has fee-for-service Medicaid coverage. If the participant transitions to an MCO or MCCN, that contract entity is the source for submission of any prior approval requests and/or reimbursement of the items or service.

J-202.2 Electronic Claim Submittal

Any claims that do not require attachments or accompanying documentation may be billed electronically using the X-12 837 Professional Standard. Refer to Chapter 300, Handbook for Electronic Processing.

Providers may also submit claims directly to the Department via the Internet through the MEDI IEC system. Further information regarding MEDI IEC can be found on the Department's website.

Providers billing electronically should take 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 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. Refer to Chapter 100 for further details. Form HFS 194-M-C is included as the last page for each Remittance Advice that reports the disposition of electronic claims.

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.

J-202.3 Paper Claim Preparation and Submittal

For general information on policy and procedures regarding claim submittal, and billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100.

Form HFS 1443, Provider Invoice, is to be used to submit charges for services covered primarily by the Department or secondary to TPL. Detailed instructions for its completion and mailing are included in Appendix J-1.

Form HFS 3797, Medicare Crossover Invoice, is to be used to submit charges for Medicare cost-sharing when services are allowed primarily by Medicare. Detailed instructions for its completion and mailing are included in Appendix J-2.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix J-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scanability/imaging evaluation. Turnaround on a claim scanability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address.

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

J-202.4 Payment

Payment made by the Department 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 for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

J-202.5 Fee Schedule

Fee schedules, including the Therapy Fee Schedule, are posted to the Department's website under the Provider Medicaid Reimbursement page. The listings identify the allowable procedure codes by provider type.

Providers will be advised of major changes via an electronic notice. Providers should sign up to receive electronic notification of new releases on the Department's website. Please mark "All Medical Assistance Providers' as well as each specific provider type for which notification is requested.

J-203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Adm. Code 140.3. A practitioner's order must be on file and services must be provided in accordance with a definite plan of care established by the therapist or clinical fellow, for the purpose of attaining maximum reduction of a physical disability and/or restoration of the individual to an acceptable functional level. Once the therapist or clinical fellow has established a plan of care, a licensed therapy assistant under the therapist's supervision may also provide treatment.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

Any questions a provider may have about coverage of a particular service should be directed to the Department prior to provision of the service. Providers may call the Bureau of Professional and Ancillary Services at 1-877-782-5565.

If services are to be provided to a participant enrolled in Care Coordination, prior authorization and payment must be obtained from the Care Coordination entity.

J-203.1 Practitioner Orders

A written recommendation (order) signed and dated by the patient's practitioner (i.e., M.D., D.O., APN, Physician Assistant and a D.C. only when working within the scope of practice) is required for the provision of therapy services.

Either electronic or handwritten dates are acceptable. Orders transmitted by telefax or electronically are acceptable, provided it is clear from the contents that the practitioner personally signed and dated the original order. Multiple page orders must have the patient's name on every page.

The practitioner order must indicate the specifications for the therapy services. **The order must be unique to the patient.** A generic or template version of an order will not be accepted. It is the responsibility of the requesting provider to have practitioner orders on file for therapy services rendered.

Services ordered by an advanced practice nurse, pursuant to a current written collaborative or practice agreement required by the Nursing and Advanced Practice Nursing Act [225 ILCS 65] and implementing rules (68 Ill. Adm. Code 1300), will be covered to the extent that the service would be covered if it were ordered by a physician.

Services ordered by a physician assistant, pursuant to written guidelines required by the Physician Assistant Practice Act of 1987 [225 ILCS 95] and implementing rules (68 Ill. Adm. Code 1350), will be covered to the extent that the service would be covered if it were ordered by a physician.

Therapy is limited to addressing the diagnosis included in the practitioner's written order. Services should be provided for participants because of illness, disability or infirmity in accordance with a plan of care established by a therapist in conjunction with the ordering practitioner.

Practitioner orders must include:

- Name of patient
- Diagnosis
- Therapy discipline (must be specific)
- Date
- Signature of practitioner with credentials

Practitioners are required to order the therapy. Orders are valid for 12 months.

Prior to the end of the initial certification, the therapist should reevaluate or reassess the participant to certify therapy continues to be medically necessary and appropriate. If a participant needs further therapy, a new plan of care and request for prior approval must be submitted to the Department.

J-203.2 Occupational Therapy

Covered Occupational Therapy services include medically necessary evaluations and treatment by a licensed Occupational Therapist when: a) services are required because an illness, disability or infirmity limits functional performance; and b) Occupational Therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when Occupational Therapy services will increase independence and/or decrease the need for other support services.

Services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and restoration of the client to an acceptable functional level.

J-203.3 Physical Therapy

Covered physical therapy services include medically necessary evaluations and treatment by a licensed Physical Therapist when: a) services are required because an illness, disability or infirmity limits functional performance; and b) Physical Therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when physical therapy services will increase independence and/or decrease need for other support services.

Services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and restoration of the participant to an acceptable functional level.

J-203.4 Speech and Language Therapy

Covered speech therapy services include medically necessary evaluations and treatment by a licensed speech language therapist when: 1.) services are required because an illness, disability or infirmity limits functional performance; and 2.) speech therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when speech language therapy services will increase independence and/or decrease need for other support services

Services must be provided in accordance with a definite plan of care established by the therapist or clinical fellow, for the purpose of attaining maximum reduction of a physical disability and restoration of the participant to an acceptable functional level.

J-203.5 Billing for Assessment Required by DME Form 3701H, Seating/Mobility Evaluation

The HFS 3701H, Seating/Mobility Evaluation (pdf), contains questions that must be completed by a licensed physiatrist or physical or occupational therapist. The therapist should not have any affiliation with the DME provider; the manufacturer of the recommended equipment; or long term care facility where a participant resides. Therapists may bill current CPT evaluation codes for the services associated with that evaluation as specified in the Therapy Fee Schedule. The Therapy Fee Schedule Crosswalk has been modified to crosswalk Wheelchair Management (e.g., Assessment, Fitting, Training) to the appropriate evaluation procedure codes for the purposes of completing the Seating/Mobility Evaluation requirement.

Evaluation codes billed by the therapist for the power mobility device or the custom manual wheelchair assessment do not require prior approval.

J-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

The objective of the Department's Medical Programs is to enable eligible participants to obtain necessary medical care. "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity, or impairment.

Therapy is for the purpose of attaining reduction of a physical disability and/or restoration of the individual to an acceptable functional level. Services provided for the general good and welfare of participants, such as fitness exercises and activities to provide diversion or general motivation, and maintenance therapy to maintain the current level of function, are not covered.

Treatment related to recreational/sports/leisure goals that does not demonstrate medical necessity is not covered.

Therapy services should not replace a home exercise program (HEP) that can be demonstrated and implemented by the participant and/or family.

J-205 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100 for record requirements applicable to all providers.

For therapy services, the basic record must include:

- Current practitioner's order signed by a physician (M.D., D.O. or D.C.), advanced practice nurse, or physician assistant
- Clinical diagnoses, if not included in the practitioner's order
- Participant's name, recipient identification number (RIN) and address
- Initial assessment and treatment plan
- Progress reports
- Approved prior authorization requests, if applicable

Refer to Topic J-203.1 for further explanation of what constitutes an acceptable practitioner's order.

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 Office of Inspector General and/or the appropriate law enforcement agency for further action.

J-206 Hospice Service Limitations

Hospice is an alternative to traditional care for the terminally ill which emphasizes the reduction of pain and other symptoms of mental or physical distress and meeting the special needs of the terminally ill.

Effective with dates of service on and after July 1, 2012, Public Act 097-0689, known as the Save Medicaid Access and Resources Together (SMART) Act, mandated the Department to establish utilization controls to prohibit other care services when an individual is in hospice.

Per 89 Ill. Admin Code Section 140.469(h), for adults 21 years of age and over, therapy services are not covered for **non-hospice providers** serving adult patients enrolled in the Department's hospice program.

Section 2302 of the Affordable Care Act, titled "Concurrent Care for Children," amends sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition of receiving curative treatment upon election of the hospice benefit for a Medicaid or Children's Health Insurance Program (CHIP) eligible child.

Eligible children through age 20 may elect to receive the hospice benefit, but also continue to be eligible to receive covered curative treatment. HFS will reimburse providers for services rendered and items supplied to children through age 20.

J-207 Services for Illinois Department of Corrections/Illinois Department of Juvenile Justice Inmates

Therapists who submit claims for professional services rendered in the hospital inpatient, outpatient, and emergency room settings must submit inmates' claims directly to HFS under the therapist's name and NPI. A claim must contain an applicable Place of Service code as identified in Appendix J-1.

Hospitals that bill fee-for-service for therapy services must also submit their fee-for-service claims to HFS.

Providers are reminded that hospital-owned offsite clinics within a 35-mile radius of the main hospital are considered part of the hospital for outpatient billing purposes.

Services for these patients billed to HFS that are not performed in the inpatient, outpatient, or emergency room setting will be denied with Error Code H05 – Service Not Covered-Recip IDOC/IDJJ. Any service **not** performed in these settings must be billed to the IDOC or IDJJ medical vendor for adjudication. Providers may contact HFS at 217-782-3541 for IDOC/IDJJ medical vendor information.

J-211 Prior Approval Process

The Department has required prior approval for adult therapy services since July 1, 2012, in order to comply with the requirements of Public Act 097-0689(pdf), which limited adult therapy services to 20 visits per year, per discipline. Public Act 098-0651(pdf) later removed those visit caps for adults but required prior approval for **all** therapy services, prompting the Department to implement the addition of prior approval for physical and occupational therapy for children through age 20 effective November 16, 2015. Speech therapy prior approval for children will be implemented at a later date.

The Department's Bureau of Professional and Ancillary Services is designated as the approving authority for therapy services.

If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100 for a general discussion of prior approval provisions.

The Department will not give prior approval for a service if a less expensive service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the participant's eligibility on the date of service. See Topic J-210.1 for eligibility verification.

If a participant becomes enrolled in an MCO or MCCN during a period of time for which a prior approval has been previously granted, the prior approval will no longer be applicable effective with the participant's managed care enrollment date. Prior approval requests for participants in an MCO or MCCN should be directed to the individual plan.

Prior approval by the Department is required for the provision of all therapy services **except** when the service is:

- Approved by Medicare
- Reimbursed by an MCO or MCCN as indicated above in this topic
- Speech therapy rendered to a child through age 20
- A therapy evaluation visit

When the Department issues a computer-generated prior approval notification, the HFS 3076A, it specifically identifies:

- The participant's name and Recipient Identification Number (RIN)
- The quantity of visits approved
- The time period for which the therapy services are approved
- The provider name and address
- Prior Approval reference number

Except for quantity, a claim submitted for payment must match the prior approval exactly or the claim will be rejected. The quantity billed may be either the same as or less than the maximum quantity approved. The date of service must be within the approved prior approval date range. Substitutions may not be made without contacting the Department to request a change in the prior approval. Approvals are patient and provider specific.

J-211.1 Prior Approval Requests

Prior approval requests must contain documentation for Department staff to make a decision on medical necessity, appropriateness, and the anticipated patient benefits of the service.

The single most common reason for a delay in processing prior approval requests is lack of adequate information upon which to make an informed decision.

Prior approval requests may be submitted to the Department by mail or fax.

By Mail:

The provider is to complete Form HFS 3701T, Therapy Prior Approval Request Form, when requesting covered services. Instructions for its completion and mailing are found in Appendix J-3.

All prior approval request forms must be signed in ink by the provider or his or her designee. Form HFS 3701T must be accompanied by a current signed and dated practitioner order for the services requested. Submitting the HFS 3701T, practitioner order, evaluation or reassessment, plan of care, and any other information to document medical necessity when the initial request is made will prevent delays in processing the request.

By Fax:

Prior approval may be requested by fax. Complete Form HFS 3701T, following the procedures described above for mailed requests. The completed form, the practitioner order, evaluation or reassessment, the plan of care, and other documents that substantiate medical necessity can be faxed to 217-524-0099. **Providers should review the documents before faxing to ensure that the information will be legible upon receipt.** Colored documents do not fax clearly. The Department recommends that such documents be photocopied and the copy be faxed.

The fax number for **initial and renewal prior approval requests** is 217-524-0099.

The fax number for **additional information and change requests** of an existing prior approval is 217-558-4359.

The fax lines are available Monday through Friday, 8:30 AM to 5:00 PM, except holidays.

The Department is not responsible for any documentation sent to the incorrect fax line and will not process documentation that is sent to the incorrect fax line.

J-211.2 Approval of Service

If the service requested is approved, the provider and the patient will receive a computer-generated letter, form HFS 3076A, Prior Approval Notification, listing the approved services. Upon receipt of the Prior Approval Notification, the provider may bill.

Any changes/corrections needed to the prior approval must be submitted as a review via fax with supporting documentation to the prior approval unit. Changes can be made on the HFS 3076A form and faxed to the Review Fax line at 217-558-4359. Additional information may be faxed after a therapy has been approved only when requested by the Department.

J-211.3 Denial of Service

If the service requested is denied, a computer-generated Form HFS 3076C, Notice of Decision on Request for Therapy, citing the denial reason, will be sent to the patient and the provider. **The provider cannot file an appeal of the denial; only the patient may file an appeal.** If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

J-211.4 Change in Prior Approval Status

Therapy approvals are not transferable. They are specific to a participant and to a specific provider.

The provider is responsible for ensuring that the HFS 3076A reflects the appropriate information. If approval has been obtained, but corrections are needed, the provider must submit a review request within 180 days of the approval notification. Prior approvals will not be changed after 180 days. This review can be faxed to the Prior Approval Unit Review Fax Line at 217-558-4359. The provider may note the corrections on the approval notice (HFS 3076A). The Department will send a revised approval notification when the update has been completed. The provider’s timely filing date will be from the date of the update to the participant’s prior approval. If a provider needs to cancel a prior approval request, these can also be directed to the review fax line at 217-558-4359.

J-211.5.1 Transfer from One Provider to Another

Patients are entitled to a choice of providers and may choose to change providers for ongoing needs.

The Department requires a cancellation statement from the former provider. The cancellation information should be sent to the Review Line at 217-558-4359 documenting the correct dates and visits used. The Department will end the prior approval and the new provider can then submit a prior approval request under its name and provider number/NPI with the medical justification.

J-211.5.2 Recipient Identification Number Change

If a patient's recipient identification number changes, then the provider must cancel the approval under the former identification number. The provider must then submit a corrected HFS 3701T with the new recipient number and medical documentation.

J-211.6 Timelines

The Department is obligated to make a decision on prior approval requests within specified time frames, as identified in 89 Illinois Administrative Code Section 140 Table E. In general, decisions must be made within thirty (30) days of receipt of a properly completed request, with exceptions as described below. If a decision has not been made within the thirty (30)-day period, the service is automatically approved, but for a minimum time period. If a service has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the rendering provider or the practitioner who ordered the service. If additional information is requested within fourteen (14) days of receipt of the prior approval request, the thirty (30)-day period stops. When the required information is received, a new thirty (30)-day period begins.

The provider can request status of a prior approval after thirty (30) days from the date of the provider's initial request. This can be done via mail, fax or by calling the prior approval unit at 1-877-782-5565.

J-211.7 Post Approvals

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Department's Medical Programs was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than 90 days following the Department's Notice of Decision approving the patient's application.

- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. To be considered under this exception, documentation that the provider billed a third party payer within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than 90 days from the date of final adjudication by the third party.

- The patient did not inform the provider of his or her eligibility for medical assistance. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval of the item must be met and the Department must receive the post approval requests no later than 90 days from the date services were provided or within the time frames identified above.

Providers have 180 days from the date of the post approval to bill the Department. If necessary, the Department will override the timely filing limit.

J-218 Medicare

For patients with Medicare coverage, charges must be first submitted to Medicare. The Department will consider Medicare's approval of a service to be a determination of medical necessity. If the claim does not crossover automatically from Medicare, providers may bill the Department for consideration of co-insurance and deductibles on Medicare-allowed items by submitting an HFS 3797, Medicare Crossover Invoice. Medicare/Medicaid crossover claims must meet the 24-month timely filing limitation as stated in 89 Illinois Administrative Code section 140.20.

For dates of service July 1, 2015 and after, providers may bill the Department for Medicare co-insurance and deductibles for individuals enrolled in a Medicare Advantage Plan (MAP) and Medicaid. HFS will consider cost-sharing when the participant is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits. Additional information regarding the QMB program can be found on the QMB Medicare Savings Programs webpage.

Claims from MAPs do not automatically cross over to the Department. Providers must submit claims within the twenty-four (24) month timely filing limit for Medicare crossovers. Providers should review the Explanation of Medicare Benefits to determine if the patient has co-insurance and deductibles. Non-Institutional providers, such as therapy providers, are required to submit a paper HFS 3797, Medicare Crossover Invoice or 837P to the Department. Claims must be completed in the same manner as original fee-for-service Medicare crossover claims.

Refer to Appendix J-2 for specific instructions on billing Medicare/Medicaid crossover claims.

Refer to the Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, for more information on the relationship between the Department's coverage and Medicare coverage.

If Medicare denies a claim, the provider must obtain a prior approval before submitting charges to the Department. The HFS 1443, a copy of the EOMB, and the HFS 1624 Override Form must be submitted to a billing consultant.

In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- The patient was not eligible for Medicare benefits, or
- The service is not covered as a Medicare benefit.

Provider billing errors and contractual obligations will not be considered for payment.

If the provider requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

If charges are denied by Medicare for a service for which the Department requires prior approval, a post approval request may be submitted but it must have the Medicare EOMB attached to explain the reason for denial. Such requests must be submitted within 90 days following final adjudication by Medicare.

Appropriate and complete documentation (including a copy of Medicare's denial, reason and date of notification) must be submitted with a provider's request for prior approval (Form HFS 3701T), evaluation or reassessment, the practitioner's order and documentation of medical necessity. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached. All limitations and requirements in Chapter J-200 apply to these requests.