999 Oakmont Plaza Drive
Suite 400
Westmont, IL 60559

July 6, 2016

Hospital Fee-For-Service (FFS) for Non-APL Billing Guide

This billing guide is intended for Hospitals billing Fee-for-Service (FFS) non-APL procedures. Hospitals should use the FFS registered Medicaid ID correlating to the applicable categories of service (COS). Hospitals eligible to render these covered services to Medicaid beneficiaries must follow the billing criteria in order to be reimbursed correctly from IlliniCare Health.

IlliniCare Health is required by the Illinois Department of Healthcare and Family Services (HFS) to meet specific claim data submission standards (encounters) requiring exact data elements on claims submitted from Hospitals. The specific mandate is as follows:

Hospital providers are required to follow specific formatting HFS guidelines of Managed Care Organizations (MCOs) related to claims submission for ancillary services.

- HFS requires that outpatient services are submitted on a CMS UB-04 paper claim form or an (837I) electronic form and must include one of the following:
    - Ambulatory Procedure Listing (APL) procedure code
    - Emergency room revenue code
    - Operating room revenue code

All hospital outpatient service billed that does not meet these three (3) criteria must be billed as FFS on a CMS HCFA 1500 paper claim form or an 837P electronic form. **IlliniCare Health will reject claims that do not meet this criteria.**

Hospitals are able to submit FFS claims when enrolled as the following Provider Types:

30 – General Hospital

FFS billable under Hospital's Name and NPI:

Hospitals are allowed to bill directly on a FFS basis for the following Categories of Service (COS):

001 Physician Services
011 Physical Therapy Services
012 Occupational Therapy Services
013 Speech Therapy/Pathology Services
014 Audiology Services
041 Medical Equipment /Prosthetic Devices
048 Medical Supplies

These Categories of Services are limited to the following procedures:

- 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
    - Tysabri
- Reference (outside) laboratory services.
- Outpatient laboratory and radiology services ordered by a physician.
- Durable Medical Equipment (DME) and Supplies:
    - Hospitals billing DME should have State approval to dispense DME and supplies (separate Medicaid number). Medical supplies and equipment or braces and prosthetic devices supplied during an APL-billable hospital outpatient visit must also be included on the hospital outpatient claim and may not be billed separately as non-APL services (FFS).
- Physical, Speech and Occupational therapy.

Claims must be billed under the hospital's name and NPI.

Addition Information Required:

- Payment for these services will be based on the same fee schedule and billable codes that applies to these services when they are provided in the non-hospital setting.
- Hospitals may bill fee-for-service for the administration of chemotherapy in the hospital outpatient setting. Hospitals may bill fee-for-service for chemotherapy drugs even if no administration fee is billed. Drugs used in the administration of the chemotherapy should not be billed through the Pharmacy Program.
- Hospital's billing for appropriate drugs include the following requirements:
    - The above drugs are the ONLY drugs that a hospital can bill for fee-for-service on the professional side.
    - Submit claims using the correct eleven-digit National Drug Code (NDC) number following the HCPCS code.

FFS not billable under Hospital's Name and NPI:

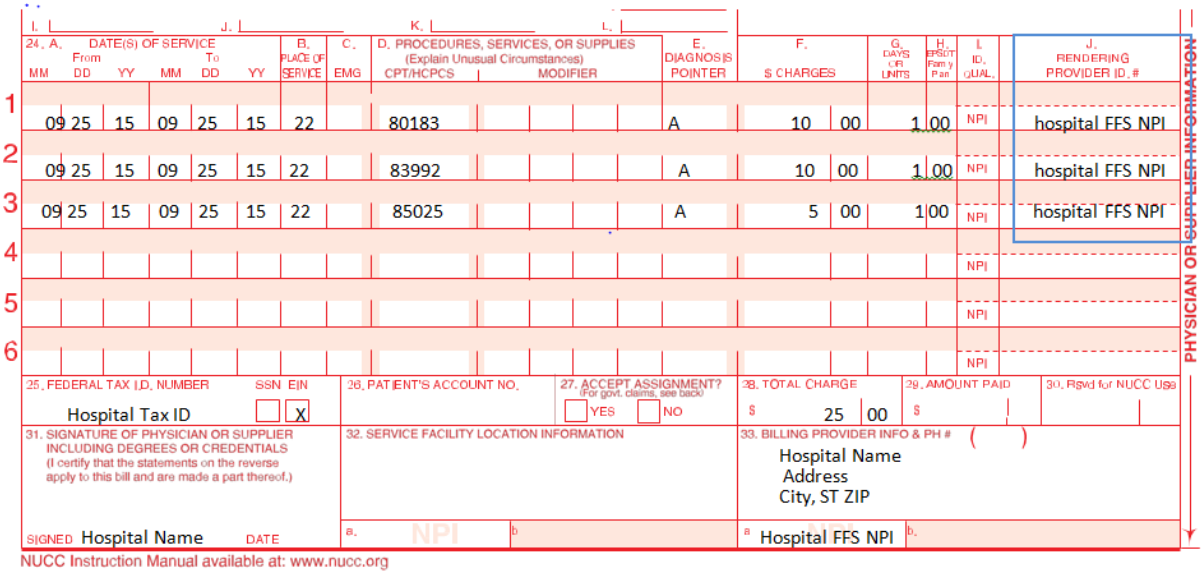
These services must be billed under the physician's name and NPI.

Hospitals may not bill fee-for-service under the facility name and NPI for the professional services of salaried physicians and APNs in the outpatient setting. These claims for professional services must be billed under the name and NPI of the practitioner who rendered the service.

This claim must be billed under the salaried physician's name and NPI:

- A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for such providers.
- A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.
- A group of physicians with a financial contract to provide emergency department care.

As an example, a Hospital billing laboratory services should bill with the Hospital FFS NPI associated with the registered Medicaid ID that correlates to COS 001. This data must be provided to IlliniCare Health in order to be accepted appropriately in all the boxes as depicted below:



24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 25 15	09 25 15	22		80183		A	10 00	1 00		NPI	hospital FFS NPI
2 09 25 15	09 25 15	22		83992		A	10 00	1 00		NPI	hospital FFS NPI
3 09 25 15	09 25 15	22		85025		A	5 00	1 00		NPI	hospital FFS NPI
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
Hospital Tax ID X		YES NO	$ 25 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED Hospital Name DATE	a. NPI b	Hospital Name Address City, ST ZIP a Hospital FFS NPI b.

NUCC Instruction Manual available at: www.nucc.org

Professional and Technical Components of Labs and X-Rays

- Charges for the professional or technical component of radiology services must be submitted with the appropriate CPT code and modifier:
  - Modifier 26 = Professional
  - Modifier TC = Technical
- If the Radiologist and/or Pathologist is salaried by the hospital, the hospital bills with no modifier for the professional and technical component reimbursement.
- If the Radiologist and/or Pathologist is NOT salaried by the hospital, the hospital bills only for the technical component (Modifier TC).
  - The professional component (Modifier 26) is billed by the Radiologist and/or Pathologist.

Drugs dispensed for treatment and/or diagnostic purposes during an inpatient stay or along with an APL procedure are included in the per diem or per discharge all-inclusive rate and no separate charge may be made.

Link for APL fee schedule:

- http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/AmbulatoryProceduresListing.aspx

Link for Series Billable Procedure Codes

- http://www.illinois.gov/hfs/SiteCollectionDocuments/010115APL3.pdf

Link for Series Billable Revenue Codes

- http://www.illinois.gov/hfs/SiteCollectionDocuments/h200a.pdf