

Medicaid Managed Care General Billing

Illinois Association of Medicaid Health Plans

Eight MCO Members (2019):

CountyCare – HealthChoice Illinois, Cook County Only

NextLevel Health – HealthChoice Illinois, Cook County Only

BCBSIL – HealthChoice Illinois, MMAI

Molina Healthcare – HealthChoice Illinois, MMAI

Meridian Health – HealthChoice Illinois, MMAI

IlliniCare – HealthChoice Illinois, DCFS, MMAI

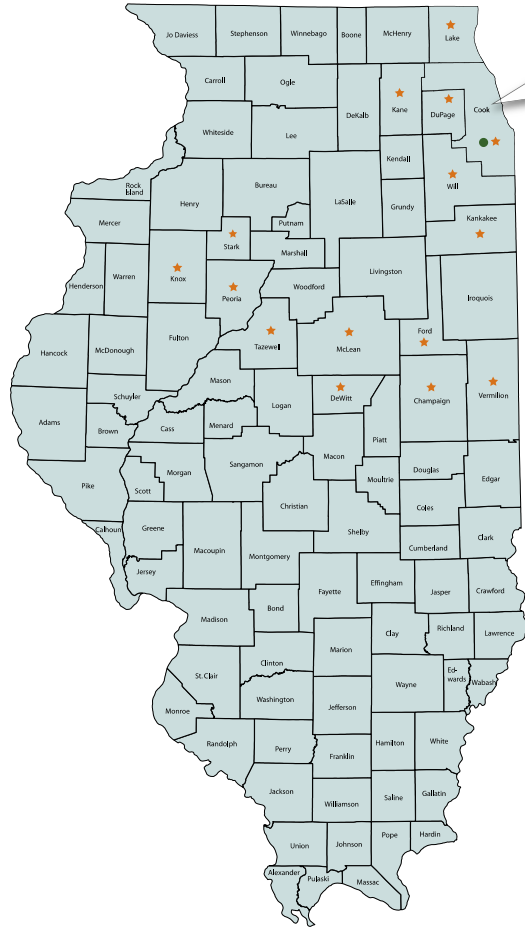
Aetna Better Health – MMAI

Humana – MMAI



Illinois Department of Healthcare and Family Services Medicaid Managed Care Program Map

January 1, 2018



All Statewide HealthChoice Illinois Plans serve Cook County.
Two Cook County HealthChoice Illinois Plans serve only Cook County. (●)

Statewide HealthChoice Illinois Plans
Blue Cross Community Health Plan
Harmony Health Plan, Inc.
IlliniCare Health
Meridian Health Plan
Molina Healthcare

Cook County HealthChoice Illinois Plans
CountyCare Health Plan
NextLevel Health Partners

Medicare Medicaid Alignment Initiative (MMAI)
Aetna Better Health Premier Plan
Cook, DuPage, Kane, Kankakee, Will
Blue Cross Community
Cook, DuPage, Kane, Kankakee, Lake, Will
Humana Health Plan, Inc.
Cook, DuPage, Kane, Kankakee, Lake, Will
IlliniCare Health
Cook, DuPage, Kane, Kankakee, Lake, Will
Meridian Complete
Cook, DuPage, Kane, Will
Molina Healthcare of Illinois
Voluntary Enrollment only: Champaign, DeWitt, Ford, Knox, McLean, Peoria, Stark, Tazewell, Vermilion



Contract & Billing Specifics



IAMHP has created a comprehensive billing guide:
<https://iamhp.net/providers>



Currently we have general billing guidelines, the outpatient hospital guide, and the inpatient hospital guide complete.



We are updating it regularly.



IAMHP welcomes your feedback and input.

IAMHP's Comprehensive Billing Guide

Resource Center

IAMHP COMPREHENSIVE BILLING GUIDE

In partnership with our provider partners, IAMHP and its member plans have developed a comprehensive billing guide to better assist providers:

[IAMHP's Comprehensive Billing Guide](#)

For specific plan inquiries or questions, please [contact the health plan directly](#).

For general questions or feedback regarding the comprehensive billing guide, please [contact IAMHP](#).

IAMHP's Comprehensive Billing Guide



This guide applies to contracted providers for the health choice program.



Billing for services provided to members enrolled in MMAI may follow different guidance.



The guidance in this document may differ from traditional commercial billing practices.

Applicable
Providers &
Members

Registering in IMPACT

- How a provider registers in IMPACT will directly affect how a provider is reimbursed by a health plan.
- Ensure that all applicable provider type, specialties, and categories of service are selected and submitted to IMPACT.
- It is paramount that the taxonomy number(s) NPI(s) are registered with IMPACT are the ones listed on claims and rosters to ensure payment.
- If providers intend to render services under multiple provider types then they need to register separately in IMPACT with separate and unique NPIs.

NPI & TIN

- NPIs and TINs that do not match on a claim are one of the most common denials Medicaid Health Plans see.
- Every claim must have a provider name, NPI, and TIN for the health facility or health professional that provided the treatment or service.
- Again, if you provide services under multiple provider types you need unique NPIs and Medicaid registrations for each provider type.

Taxonomy, Provider Type, & Category of Service

- All claims must include the 10-character specific provider taxonomy code (e.g. 207Q00000X for Family Practice, 282N00000X for General Acute Care Hospital) to be processed
- The taxonomy code used must match a corresponding Category of Service (COS), Procedure Code (PC) and/or Place of Service (POS)
- Hospitals with separate NPIs for professional categories of service and institutional categories of service must use the appropriate NPI that matches the corresponding Medicaid ID (i.e. use your institutional NPI with your institutional Medicaid ID).
- Always ensure that if you have multiple NPIs and IMPACT Medicaid IDs that they match on the claim. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, etc.

All submitted claims must:

Identify the name and appropriate TIN number of the health professional or facility that provided treatment or service, with a matching NPI number based on the billing guidance for the IMPACT provider type.

Identify the patient (RIN and/or MCO-specific Plan ID, address and date of birth)

List the date (mm/dd/yyyy) and place of service

If necessary, include any applicable prior authorization number provided by the MCO. • Have valid Diagnosis, Procedure, Modifier and Location Codes

Basic Claim Requirements

Ensure all Diagnosis Codes are to their highest number of digits available (4th, 5th, and 6th character requirements and 7th character extension requirements).



Ensure all other insurance resources (e.g. Medicare or other third-party coverage) have been exhausted before submission. Include any coordination of benefit (COB) documentation (e.g. a copy of the primary insurance EOB – including pages with run dates, coding explanations and messages) with the claim submission. Medicaid is always the payer of last resort.



Be certified by the provider that the claim:

is true, accurate, prepared with knowledge and consent of provider,

does not contain untrue, misleading, or deceptive information

Identifies each attending, referring, or prescribing physician, dentist or other practitioner

Basic Claim Requirements Continued

Important Steps for EDI Claims Submission

IMPORTANT STEPS TO SUCCESSFUL EDI SUBMISSION

- 1 Select clearinghouse to utilize
- 2 Contact the clearinghouse to inform them you wish to submit electronic claims to which MCOs.
- 3 Inquire with the clearinghouse what data records are required.
- 4 You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to the MCO, and also those claims not meeting the clearinghouse requirements. The second report will be a claims status report showing claims submitted to, but rejected by, the MCO. These claims need to be corrected and resubmitted. ALWAYS review the acceptance and claims status reports for any rejected claims.
- 5 MOST importantly, all claims must be submitted with providers' identifying numbers. See the CMS 1500 and UB-04 claim form instructions in the Appendix.



Every plan lists their prior authorization requirements:

<http://iamhp.net/resource-center-preauthorization>



Plans review prior authorization requirements regularly. If you notice an outlier notify the health plan.



Electronic Authorization requests are preferred and encouraged.

Prior Authorizations

Prior Authorization Best Practices

- **OUTPATIENT(not pharmacy) (PreService) Prior Authorization**
- Health Plans have the ability to accept prior authorization requests 24/7 and have the clinical staff to review your requests in a timely fashion.
- It is recommended that providers utilize portals and request prior authorizations electronically.
- A health plan has (48) hours to review a prior authorization marked urgent and 4 (calendar) days to review a standard prior authorization request. Providers may request an additional 4 (calendar) day extension for Standard PA requests (8 days total) to supply additional information. These timeframes apply to preservice requests.
- All clinical information needed to make a determination is necessary before the required timeframe to ensure a health plan has an adequate and complete picture of a member's condition. Without all required clinical information, a provider *risks* a prior authorization request being denied. Concise information pertinent to the requested service should be sent; not the entire medical record.
- Communicate with your health plan and request an extension. By contract, a health plan can extend the timeframe for an additional 4 (calendar) days for preservice requests.

Prior Authorization Best Practices

- **INPATIENT Notification and Prior Authorization**
- Notify the member's health plan within 24 hours of admission.
- It is recommended that providers utilize portals and request prior authorizations electronically.
- A health plan has 2 (calendar) days to review an elective inpatient prior authorization marked urgent and 4 (calendar) days to review an elective inpatient authorization marked standard prior authorization request. For Inpatient Emergent admissions health plans have 1 (calendar) day to return the decision. If no clinical information is received, the health plan can extend the decision an additional 2 (calendar) days (3 calendar days total) to allow time for the facility to send the information.
- If you do not have complete clinical information within the required timeframes then it is recommended you do the following:
 - The Health Plan will request additional clinical information and the timeframe may be extended up to 72 hours for an inpatient stay.
- At any point during the inpatient stay, notify the Health Plan as soon as possible of any anticipated barriers to discharge or changes to clinical conditions so that the health plan can assist with the discharge planning process.



Outpatient Hospital Specifics



This guidance is for general acute hospital inpatient services.



NPIs should be registered as provider type 30.



Effective with dates of service beginning 7/1/2014, all outpatient/ambulatory claims are grouped and reimbursed through 3M EAPG software, or similar MCO grouper software.



MCOs use the same grouper version as HFS.

General Outpatient Guidance

Claim Type Guidance

- All hospital outpatient/ambulatory claims must be submitted on a UB-04 (837I) claim form and MUST include one of the following:
 - A valid Ambulatory Procedure Listing (APL) procedure code, which is valid on the date of service and/or
 - At least one Emergency Department (ED) revenue code with an associated HCPCS code; and/or
 - At least one Observation (OBV) revenue code with any associated HCPCS codes.
- Failure to have an APL code, ED revenue code, and/or OBV revenue code will result in a denial of the entire claim by the MCO.

APL categories of service billed on UB04

- 024 Outpatient Services (General)
- 025 Outpatient Services (ESRD)
- 027 Psychiatric Clinic Services (Type A)
- 028 Psychiatric Clinic Services (Type B)
- 029 Clinic Services (Physical Rehabilitation)

APL categories of service billed on CMS 1500

- 001 Provider Services
- 011 Physical Therapy Services
- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services
- 014 Audiology Services
- 017 Anesthesia Services
- 030 Healthy Kids Services
- 040 Pharmacy Services (Legend and OTC)
- 041 Medical Equipment/Prosthetic Devices
- 048 Medical Supplies

Billing Observation Services

- Since 1/1/2017, all observation claims must be billed with Revenue Code 0762 and HCPCS codes G0379 and G0378.
- Hospitals must use two revenue lines for observation, with the first Rev Code 0762 billed with HCPCS code G0379 representing one (1) unit along with zero-dollar (\$0.00) charges
- AND a second Rev Code 0762 billed with HCPCS code G0378 representing the number of time based units along with the corresponding charges.
- For observation services that span multiple days (i.e. cross midnight): this is considered a single episode of care and an APL must be present on at least one of the dates of service (e.g. Rev Code 0450 with HCPCS 99284). However, both the G0378 and G0379 HCPCS are required for each day of service, in addition to the APL code.

NDC Guidance

- Plans use either Medispan or First DataBank to validate NDC
- The standard code set for NDCs is eleven (11) digits in a 5-4-2 configuration with no hyphens, spaces, or other characters.
- Use the modifier JW in FL 44 to identify the drug amount remaining from a single use vial that is discarded or not used.
- Providers are required to detail revenue code line reporting when billing for more than one NDC per HCPCS code in conjunction with ANY revenue code. Each Revenue Code line must contain detailed reporting.

Additional Guidance available in the Comprehensive Billing Guide

- Psychiatry billing guidance
- Series billing guidance
- Specific claim scenarios
- 340 B guidance
- Billing guidance for a salaried provider
- Plan specific information i.e. EDI and clearinghouse information



Additional Resources

Illinois Department of Healthcare and Family Services – Care Coordination Homepage



TRANSITION
LETTERS AND CLIENT
COMMUNICATIONS



PROGRAM
DESCRIPTIONS



ENROLLMENT
INFORMATION



CARE
COORDINATION
QUALITY METRICS



HEALTHCHOICE
ILLINOIS 2018 MODEL
CONTRACT



In addition to the Key Contacts and Billing Guides, the Info for Providers section also includes links to Provider Manuals and Prior Authorization links



Regular updates to reflect any URL changes, document updates, etc.



IAMHP always welcomes suggestions, so please don't hesitate to share what additional information we can collect from the health plans and post to our site.

IAMHP Website – Info for Providers

IAMHP Key Contacts

Key Contacts for Providers

To find the contact you are looking for, simply navigate to that page using the link provided. **IAMHP no longer maintains a printed directory.**

By Topic Area

[Children's Services](#)

[Community Mental Health](#)

[Dental](#)

[Durable Medical Equipment](#)

[Federally Qualified Health Centers \(FQHC\)](#)

[Home Health](#)

[Hospice](#)

[Hospitals](#)

[Long Term Care](#)

[Mental Health](#)

[Methadone Treatment](#)

[Pharmacy / Pharmaceuticals](#)

[Physicians](#)

[Public Health Departments](#)

[Redetermination Point Person](#)

[Substance Use Disorder](#)

Report a Contact Change

Help us keep this information up-to-date. Notify our team using the form below if you see any inaccuracies.

Your Role in Requesting a Change *

- I am a Directory User who believes a listing is incorrect
- I am an Organization Designee who needs to report a change

Requested Change *

- Remove a Contact (This person is no longer the contact, but there is no replacement yet)
- Add Contact (New person, but not replacing anyone)
- Replace Contact (Remove this person and replace them with someone else)
- Other

Please describe the change in detail below.

If you are adding a new contact, we need to know:

- Their name
- Their title
- Organization (if different from yours)
- Their phone number
- Their email address
- Their areas of responsibility / committees / topics that they should be listed under

Change Needed *



Samantha Olds Frey,
Executive Director

samantha@iamhpteam.org



Alaina Kennedy,
Associate Director

alaina@iamhpteam.org

IAMHP Contact Information