Handbook for Providers of Encounter Clinic Services

Chapter D-200
Policy and Procedures
For Encounter Clinic Services

Illinois Department of Healthcare and Family Services
Issued August 2016

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Encounter Clinic Services
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Foreword

Purpose

This handbook has been prepared for the information and guidance for providers enrolled as an encounter clinic, except encounter clinics owned and operated by a county with a population of over three million, to provide primary care services to participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

The Handbook for Providers of Encounter Clinic Services can be viewed on the Department's website.

It is important that both the provider of service and the provider's billing personnel read all materials, prior to providing services, to ensure a thorough understanding of the Department's policies and procedures. Revisions and supplements to this Handbook will be released as operating experience and/or state or federal regulations necessitate. The updates will be posted to the Department's website on the Provider Notices page.

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.

Providers will be held responsible for compliance with all policies and procedures contained herein.

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

Chapter D-200
Encounter Clinic Services

D-200 Basic Provisions

For consideration of payment by the Department, encounter clinic services must be provided by a clinic enrolled in the Department's Medical Programs. The clinic must fall into one of the clinic categories described below.

- **Federally Qualified Health Center (FQHC)** – A health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Service Administration, U.S. Department of Health and Human Services.

- **Rural Health Clinic (RHC)** – An RHC can be either a freestanding health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) (42 USC 1395x (aa)(2)) to be an RHC, **or;** a provider based health care provider that is an integral part of a hospital that is participating in the Medicare program and is licensed, governed and supervised with other Departments within the hospital.

- **Encounter Rate Clinic** – A health care provider that was actively participating in the Department's Medical Assistance Program as an Encounter Rate Clinic as of July 1, 1998.

Encounter clinic services must be provided in full compliance with the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, the Chapter A-200, Handbook for Practitioners Rendering Medical Services 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 services rendered to participants enrolled in traditional fee-for-service, Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs) and do not apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). The Department is not to be billed for services if the participant is enrolled in a MCO or a MCCN. A participant's enrollment with an MCO and MCCN can be verified on Medical Electronic Data Interchange (MEDI) Internet Site and Recipient Eligibility Verification (REV) System under the "Managed Care Organization" segment. A List of Contacts for the Medicaid Health Plans is available on the Department's Web site.

Providers submitting X12 electronic transactions must refer to Chapter 300, Professional (837P) Standard Companion Guide. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare programs funded or administered by the Illinois Department of Healthcare and Family Services.

D-201 Provider Enrollment

Each clinic site is required to enroll with the Department in order to be considered for reimbursement. If multiple sites are owned or operated by the same entity, each site must be enrolled separately.

When enrolling, each clinic site must designate the specialty/subspecialty for the services they will provide. FQHCs and RHCs may enroll to provide medical encounters, behavioral health encounters and dental encounters. ERCs may enroll to provide medical encounters and dental encounters.

D-201.1 General Enrollment Requirements

Clinics/centers are eligible to be considered for enrollment to participate in the Department's Medical Programs.

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented a new 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 (FQHC, RHC, ERC) must be selected. A provider type subspecialty may or may not be required. For example, if the clinic/center is enrolling for behavioral health or dental, those subspecialties must be identified in IMPACT.

As described in Topic D-210.5.3, there are limited circumstances under which a clinic/center may enroll as another provider specialty/subspecialty.

Refer to IMPACT Provider Types, Specialties and Subspecialties for additional information. Licensing and certification requirements for each provider type, specialty and subspecialty are identified in IMPACT.

D-201.2 Primary Care Case Management Program and Care Coordination

Physicians, clinics, and health centers that are enrolled to participate in the Department's Medical Programs may enroll in the Department's statewide Primary Care Case Management (PCCM) program, Illinois Health Connect, as a PCP. To learn more about the Illinois Health Connect program, or to enroll as a PCP, please visit the Illinois Health Connect website or call the Illinois Health Connect Provider Helpdesk at 1-877-912-1999 (8 a.m. - 7 p.m. Monday through Friday).

According to state law, HFS enrolls Illinois Medicaid and All Kids participants into care coordination in five mandatory managed care regions: Rockford, Central Illinois, Metro East, Quad Cities, and the greater Chicago area. A List of Contacts for the Medicaid Health Plans is available on the Department's Web site.

Refer to the Handbook for Providers of Medical Services, Chapter 100 – General Policies and Procedures for more information on verifying eligibility.

Descriptions of the Department's care coordination health plans and other care coordination programs are available on the Department's Care Coordination webpage.

D-201.3 Enrollment Approval

When enrollment is approved, the provider will receive a computer generated notification, the Provider Information Sheet, listing all 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 D-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 D-201.5.

When there is a change in ownership greater than 50%; a change in the clinic location, name, or a change in the Federal Employer's Identification Number, a new application for participation and other necessary documents must be completed. Claims submitted by the new ownership using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

D-201.4 Enrollment Denial

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

Within ten (10) 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 (10) 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 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.

D-201.5 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.

Provider change information can be communicated to the Department via the on-line application available on the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) Provider Enrollment webpage. The on-line change function is available to notify the Department of updates or changes to enrollment information for the following categories:

- National Provider Identifier (NPI).
- Provider name.
- Provider demographic (addresses, phone, email).
- Payee demographic (addresses, phone, email).
- Add a Pay To (payee).
- Close a Pay To (payee).
- Close enrollment.
- License.
- Clinical Laboratory Improvements Amendments (CLIA).

Failure of a provider to properly update IMPACT to reflect changes or corrections to provider information 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 Pay To (payees) listed if the address is different from the provider address.

D-202 Encounter Clinic Reimbursement

The billing instructions contained within this handbook apply to participants enrolled in traditional fee-for-service, Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs) and **do not apply to participants** enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs).

The Department is not to be billed for services if the participant is enrolled in a MCO or a MCCN. Charges for services provided to participants enrolled in a MCO or MCCN must be submitted to the MCO or MCCN. A participant's enrollment with an MCO and MCCN can be verified on Medical Electronic Data Interchange (MEDI) Internet Site and Recipient Eligibility Verification (REV) System under the "Managed Care Organization" segment. A List of Contacts for the Medicaid Health Plans (pdf) is available on the Department's Web site.

D-202.1 Charges

Providers may only bill the Department after the service or item has been provided. The clinic/center will be reimbursed at the all inclusive rate established by the Department for the type of encounter service rendered, except when billing allowable fee-for-service charges as listed in Topic D-210.5.

To be eligible for reimbursement, all claims, including claims that have been corrected and resubmitted, must be received by the Department within 180 days 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.

D-202.2 Claim Preparation and Submittal

Refer to the Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 112 for general policy and procedures regarding claim submittal. Refer to appendices for technical guidelines to assist in claim preparation and submittal.

D-202.3 Paper Claim Submittal

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. 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: Provider/Image System Liaison

D-202.4 Electronic Claims Submittal

Any services that do not require attachments or accompanying documentation may be billed using the 837P electronic transaction. Further information concerning electronic claims submittal can be found in Topic 112 of the Chapter 100 handbook and the Chapter 300, Professional (837P) Standard Companion Guide.

Chapter 300 identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare programs funded or administered by the Illinois Department of Healthcare and Family Services.

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, for further details.

D-202.5 Payment

Payment made by the Department for allowable encounter services will be made at the all-inclusive rate established by the Department for each encounter. The all-inclusive encounter rate covers the face-to-face visit and all other ancillary services provided on the date of service. Topic D-210.1 provides detailed information on what constitutes an allowable encounter service. Payment for services rendered as allowable fee-for-service will be paid at the fee-for-service rates. Refer to the Practitioner fee schedule for more information.

D-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. Refer to Chapter 100 handbook for a general list of covered services. Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

203.1 Core Services

The services listed below are considered core services of the clinic/center:

- Physician services, including covered services of nurse practitioners, nurse midwives, and physician-supervised physician assistants.
- Dental services rendered by a dentist.
- Behavioral health services rendered by a licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist.
- Preventive Services**,** as defined in *Section 1861(ddd)(3) of the Social Security Act,* which include, but are not limited to:
    - Required school examinations for children.
    - Periodic well-child services (visits, immunizations and screenings) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.
    - Preventive services for adult participants, age 21 and older.
    - Cancer screenings.

Services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a billable medical, behavioral health or dental encounter, of kinds which are commonly furnished in the practitioners' offices and are commonly either rendered without charge or included in the practitioners' bills, are considered a component of the encounter and cannot be billed fee-for-service (FFS) or as an encounter. Examples of these services include, but are not limited to:

- Injections (allergy, antibiotic, steroids, etc.).
- Medical case management.
- Patient transportation.
- Health education.
- Nutrition services.
- Onsite laboratory tests:
    - Chemical examination of urine by stick or tablet method or both.

- Hemoglobin or hematocrit.
- Blood sugar.
- Examination of stool specimens for occult blood.
- Pregnancy tests.
- Primary culturing for transmittal to a certified laboratory.

D-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to Chapter 100 handbook, for a general list of non-covered services.

D-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 handbook, for record requirements applicable to all providers.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the health care provider rendering services.

The record maintained at the encounter clinic is to include the essential details of the patient's condition and of each service provided. Any services provided to a patient outside the clinic setting must be documented in the medical record maintained at the clinic. All entries must include the date and must be legible and in English. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition and treatment and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the clinic as an office record to show continuity of care.

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.

D-210 General Limitations and Considerations on Covered Services

The same policy and procedures that apply to practitioners also apply to the encounter clinic. Refer to Chapter A-200, Handbook for Practitioners Rendering Medical Services for detailed Department policy regarding medical care.

D-210.1 Definition of Encounter

Encounter services must be rendered in a clinic, patient's home or long term care facility if the facility is the patient's permanent place of residence, or school if the clinic has a school-based or school-linked specialty. Only one medical encounter per patient per day can be billed to the Department. If the clinic is enrolled for dental or behavioral health services, only one dental and one behavioral health encounter per patient per day is eligible for reimbursement.

A billable encounter is defined as one of the following:

- Medical face-to-face visit with a physician, physician assistant, or Advance Practice Nurse
- Behavioral health face-to-face visit with a licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist, as applicable
- Dental face-to-face visit with a dentist

Dental encounter claims must be submitted to the Department's dental contractor, DentaQuest. For billing information, refer the Dental Office Reference Manual (pdf).

Note: For dates of service prior to October 1, 2016, when a vaccination or lab service is rendered by clinic staff and the service does not meet the definition of a medical encounter as defined above, a non-physician wellness service (S5190) should be billed to the Department for reporting purposes. In addition, procedure codes detailing the wellness service must be listed in order to update the child's state health profile. For dates of service on and after October 1, 2016, refer to Appendix D-6, Vaccine Billing Instructions, for detailed billing instructions.

D-210.2 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. Group psychotherapy is not a covered telepsychiatry service.

Under the Department's telehealth policy, providers will be paid as either an Originating Site or Distant Site. Refer to Appendix D-3 for billing examples.

D-210.2.1 Originating Site (Patient Site)

The Originating Site is the site where the patient is located. An encounter clinic serving as the Originating Site shall be reimbursed their medical encounter. The Originating Site encounter clinic must ensure and document that the Distant Site provider meets the Department's requirements for telehealth and telepsychiatry services since the clinic is responsible for reimbursement to the Distant Site provider.

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.

D-210.2.2 Distant Site (Provider Site)

The Distant Site is the site where the provider rendering the telehealth service is located. The Distant Site shall be reimbursed as follows:

- If the Originating Site is an encounter clinic, the Distant Site may not seek reimbursement from the Department for their services. The Originating Site encounter clinic is responsible for reimbursing the Distant Site.

- If the Originating Site is not an encounter clinic, the Distant Site encounter clinic can seek reimbursement from the Department.

For telemedicine services, the provider rendering the service at the Distant Site can be a physician, podiatrist, advanced practice nurse (APN), or a Physician Assistant (PA) who is licensed by the State of Illinois or by the state where the participant is located.

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. Telepsychiatry is not a

covered service when rendered by an APN or PA. Group psychotherapy is not a covered telepsychiatry service.

D-210.3 Group Psychotherapy Services

Group psychotherapy services must be directly performed by one of the following practitioners:

- Physician licensed to practice medicine in all its branches who has completed an approved general psychiatry residency program or is providing the service as a resident or attending physician at an approved or accredited residency program.
- Advanced Practice Nurse (APN) holding a current certification in Psychiatric and Mental Health Nursing.
- Licensed Clinical Psychologist (LCP).
- Licensed Clinical Social Worker (LCSW).
- Licensed Clinical Professional Counselor (LCPC).
- Licensed Marriage and Family Therapist (LMFT).

Group psychotherapy services rendered by a physician or qualified APN can be billed as a medical encounter. Services rendered by a LCP, LCSW, LCPC or LMFT must be billed as a behavioral health encounter.

The group psychotherapy requirements also apply to services rendered to participants with Medicare as their primary insurance.

Group psychotherapy is not covered for participants who are residents in a facility licensed under the Nursing Home Care Act (210 ILCS 45) or the Specialized Mental Health Rehabilitation Act (210 ILCS 48).

D-210.3.1 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. Entire group psychotherapy service is directly performed by the one of the practitioners listed in Topic D-210.3.
- 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 practitioner, 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.

D-210.4 Tobacco Cessation Counseling

Tobacco cessation counseling services rendered to children through age 20 or to women age 21 and over who are pregnant or in their 60-day post-partum period, are eligible for reimbursement from the Department.

D-210.4.1 Duration of Tobacco Cessation Counseling

Pregnant women and women who are up to 60-day post-partum and age 21 and over have a maximum of three quit attempts per year, with up to four individual face-to-face counseling sessions per quit attempt. The 12 maximum counseling sessions include any combination of the billable procedure codes per year. Children through age 20 are not restricted to the maximum twelve counseling sessions.

These counseling sessions must meet the criteria of a face-to-face medical encounter. The patient's medical record must be properly documented with provider signature, and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources offered and follow-up instructions.

D-210.5 Allowable Fee-for-Service Billing

This topic describes the limited circumstances under which a clinic/center is allowed to bill the Department fee-for-service.

D-210.5.1 Clinic Staff Practitioners

When services are rendered by clinic/center staff practitioners outside the clinic or home setting, the clinic cannot bill an encounter. These services must be billed fee-for-service under the rendering practitioner's or supervising physician's NPI. An example of this would be a clinic/center staff physician seeing patients who are hospitalized. Services will be reimbursed based on the practitioner rate or the provider charges, whichever is less. Reimbursement information can be found on the fee schedule.

D-210.5.2 Long-acting Contraceptive Devices

When FQHC/RHCs purchase long-acting contraceptive devices (LARCs) and transcervical sterilization devices, the clinic can bill for the device fee-for-service. Charges must be submitted separately from the encounter. The following reimbursement criteria apply:

- To the extent that the LARCs and Transcervical Sterilization Devices were purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC or RHC's actual acquisition cost with a UD modifier.
- Reimbursement shall be made at the FQHC or RHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is less.
- This reimbursement shall be separate from any encounter payment the FQHC or RHC may receive for the insertion procedure.

D-210.5.3 Services Not Included in Cost Report

When the costs of services listed in Topic D-204 were not included in the cost report used to calculate the clinic/center's all-inclusive encounter rate and the clinic/center is enrolled separately with the Department to provide the services to the general public, the services may be billed fee-for-service (FFS). The clinic/center is responsible for ensuring that the costs associated to the services were not included in the cost report used to calculate their encounter rate prior to the services being billed to the Department. If the clinic/center's encounter rate is based on an interim rate and not their own cost report, none of the services listing in #1 below may be billed FFS. As described below, the type of service being rendered will determine how the service is billed to the Department.

1. For the services listed below the service **must** be billed under the rendering practitioner's or supervising physician's NPI with payment directed to the clinic/center's corporate NPI. The services will be reimbursed based on the Department's applicable rate or the provider charge, whichever is less. Reimbursement information can be found on the fee schedule. Applicable participant copayments will apply.
    - Audiology services.
    - Chiropractic services.
    - Occupational therapy.
    - Optometric services.
    - Physical therapy.
    - Podiatric services.
    - Speech and hearing services.

2. For non-core pharmacy and laboratory and imaging services the clinic/center must enroll in IMPACT as that provider type/specialty. As required in IMPACT, the clinic/center must have a separate NPI for each provider type/specialty for which they will be billing. The service must be billed under the separate NPI with payment directed to the clinic/center's corporate NPI. The services will be reimbursed based on the Department's applicable rate or the provider charge, whichever is less. Reimbursement information can be found on the fee schedule. Applicable participant copayments will apply.

D-210.5.4 Vaccinations

Effective October 1, 2016, vaccines for children (birth through age 18) eligible under the Title XXI [21] and State-funded medical programs through the Department are not available through the Vaccines for Children (VFC) program. Clinics are allowed to bill vaccines for this population fee-for-service. Refer to Appendix D-6, Vaccine Billing Instructions, for detailed billing instructions. Children (birth through age 18) eligible under Title XIX [19]) must receive VFC obtained vaccines when available through the VFC program. Additional information is located in the Handbook for Practitioners, A-226, Vaccinations (Immunizations).

D-214 Cost Reports

Once an FQHC/RHC has been accepted as an enrolled provider, yearly filings of the cost report and supporting documents are mandatory. If the required cost report and supplemental documents are not submitted within the required time limit, the Department will suspend payments to the FQHC/RHC. This action will remain in effect until proper submission of all the required documents. Each cost report is subject to audit by state auditors to determine proper costs. If the cost data from the cost reports is not traceable to the supplemental documents, an onsite audit will be made to determine if the clinic is eligible to continue in the FQHC/RHC program. FQHC/RHC Cost Reports must be completed by each FQHC/RHC operating in the State of Illinois and seeking payment under the provisions for FQHC/RHCs. If an FQHC/RHC within Illinois has several clinic sites, it may choose to either file one (1) cost report covering all clinic sites or file individual costs reports for each clinic site operated by the FQHC/RHC. FQHC/RHCs in contiguous states must file an Illinois cost report and audited financial statement. This documentation is required because they operate in an area where Illinois patients are served.

The FQHC/RHC must maintain financial and clinical records which are accurate and in sufficient detail to substantiate the cost data reported for a period of no less than three (3) years. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC/RHC or they will be disallowed.

Cost reports and Instructions for FQHC's and RHC's are available on the Department's website.

D-214.1 Filing of Cost Report

Federally Qualified Health Center

The FQHC must file with the Department a completed cost report and audited financial statements annually within one hundred eighty (180) days after the close of the Center's fiscal year. An FQHC cost report may be filed more often or less often than an annual period only when necessitated by the facility terminating its agreement with the Department, by a change in ownership, or by a change in fiscal period.

Improperly completed or incomplete filings will be returned to the facility for proper completion and must be resubmitted to the Department within thirty (30) days.

Each required FQHC Cost Report must be signed by the authorized individual who normally signs the FQHC's federal income tax return or similar reports. The person preparing the FQHC Cost Report must also sign the report and list his/her telephone number.

FQHC Cost Reports must be prepared in conformance with generally accepted accounting principles and the provisions of the Federally Qualified Health Center

Accounting Requirements. Cost reports must be filed using the accrual method of accounting.

Provider-Based Rural Health Center and Freestanding Rural Health Center

All RHCs must submit an annual cost report for their fiscal year within one hundred eighty (180) days after the close of the Center's fiscal year.

Free-Standing Rural Health Centers

The cost report filing requirements include form CMS 222-92 that was filed for the Medicare program. In addition, there is a cost report file on the Department's website. This cost report file consists of two Medicaid attachments which require additional information relating to form CMS 222-92. These three items must be filed with the Department within 180 days after the close of the RHC's fiscal year end.

Provider-Based Rural Health Centers

The cost report filing requirements include the form CMS 2552 worksheet M series that was filed for the Medicare program. In addition, there is a cost report file on the Department's website. This cost report file consists of two Medicaid attachments which require additional information relating to the CMS 2552 worksheet M series form. These three items must be filed with the Department within 180 days after the close of the RHC's fiscal year end.

D-214.2 Reasonable Costs – FQHC

The Department will determine if costs are reasonable and allowable by applying Medicare cost reimbursement principles, as defined by federal regulation at 42 CFR, Section 413, the Social Security Act, Section 1861(V), or as modified by the Department.

Reasonable costs of any service are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable costs take into account both direct and indirect costs of providing services, including normal standby costs.

Costs may vary from one institution to another because of scope of services, level of care, geographic location and utilization. It is the intent of the program that a clinic will be reimbursed the current actual costs of providing high quality care, regardless of how widely services may vary from clinic to clinic, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization and other relevant factors. "Utilization" for this purpose refers not to the clinic's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix, age of patients, type of illness, etc.)

D-214.3 Reimbursable Costs

Costs related to patient care include all necessary and proper costs that are incurred in developing and maintaining the operation of patient care facilities and activities.

Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the clinic's activity. This includes personnel costs, administrative costs and others. Allowance of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

D-214.4 Non-Reimbursable Costs

Women, Infant and Children (WIC) Program and Nutritional Services
Any costs related to the WIC Program or professional services provided by a clinic nutritionist are not reimbursable by the Department. These costs must be reported on the non-reimbursable section of the cost report.

Costs Not Related to Patient Care

Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of the patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals to visitors; costs of drugs sold to other than patients; cost of operation of a gift shop; non-covered services that are provided; and similar items.

D-215 Audit of Cost Reports

All cost reports submitted require a desk audit. If further information or documentation is required, a field audit may be required.

D-215.1 Desk Audit

The desk audit includes procedures that will:

- Verify the completeness and mathematical accuracy of all schedules in the report.
- Compare reported program statistics with the Department's payment data.
- Identify the need for supporting documentation and arrange to receive such documentation.
- Compare reported data with industry norms as an aid to the audit scope determination.
- Identify the need for a field audit examination and possible rate adjustment.

D-215.2 Field Audit

Field audits are performed, if necessary, in accordance with the Federal Department of Health and Human Services requirements for federal participation and include appropriate auditing procedures and techniques as are deemed necessary by the Department. The scope of the field audit will be sufficiently comprehensive to verify that in all material respects reported data is documented by supporting records and that the costs are allowable pursuant to Medicare cost reimbursement principles. If direct expenses and allocated expenses cannot be documented, they will not be allowed.

D-216 Rate Setting

Encounter rates are based on a prospective payment system pursuant to 89 IL Adm. Code 140.463(b). Once determined, the baseline encounter rate will be adjusted annually using the most recently available Medicare Economic Index (MEI). The updated rates will be effective January 1st of each year. Services provided on or after January 1st of each year will be paid the newly adjusted rate.

For any center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs with similar caseloads, as determined by the Department. If the Department determines that there are no such comparable centers, then the rate per encounter shall be the median of the payment rates per encounter Statewide for all FQHCs or RHCs.

D-217 Rate Appeals

FQHCs have the right to appeal audit adjustments or rate determinations.

Appeal Process

- All appeals must be submitted in writing to the Department. Appeals submitted within sixty (60) calendar days of the rate notification, if upheld, shall be made effective as of the beginning of the rate year.
- To be accepted for review, the written appeal must include:
  - The current approved reimbursement rate, allowable costs and the additional reimbursable costs sought through appeal,
  - A clear, concise statement of the basis for the appeal,
  - A detailed statement of financial, statistical and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement, and
  - A statement by the provider's Chief Executive Officer or Chief Financial Officer that the application of the rate appeal and information contained in the vendor's reports, schedules, budgets, books and records submitted are true and accurate.
- Rate appeals may be considered for the following reasons:
  - Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable cost
  - Mechanical or clerical errors committed by the Department in auditing historical expenses as reported or in calculating reimbursement rates

The Department shall rule on all appeals within one hundred twenty (120) calendar days of receipt of the appeal except that, if additional information is required from the facility, the period shall be extended until such time as the information is provided. Appeals must be submitted to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Health Finance
201 South Grand Avenue East
Springfield, Illinois 62763