Handbook for Home Health Agencies

Chapter R-200 Policy and Procedures For Home Health Care

Illinois Department of Healthcare and Family Services
May 2016

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Home Health Agency 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. Updates are posted on the Department's 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.

Chapter R-200

Home Health Care Services

R-200 Basic Provisions

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 apply 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). Providers submitting X12 electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 Handbook identifies information 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.

R-201 Provider Enrollment

R-201.1 Enrollment Requirements

The following providers may enroll with the Department as home health care providers:

- A Medicare-certified home health agency licensed by the Illinois Department of Public Health.
- A home nursing agency licensed by the Illinois Department of Public Health.
- A health department certified by the Illinois Department of Public Health.

Home nursing agencies providing services under the Nursing and Personal Care Services (NPCS) Program must employ nurses with valid Illinois nursing licenses with no exclusions from participation in a federal health care program. The nursing agency must ensure that all nurses employed have not been reprimanded, placed on probation or suspended for committing exploitation, assault, battery or abuse of an individual, or involved in any drug related offense, and that they have not engaged in any conduct which would constitute grounds for discipline under the Illinois Nurses Practice Act (225 ILCS 65/50-75) except discipline due to "default on student loans".

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 must be selected. A provider type subspecialty may or may not be required. 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.

R-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 further explanation of the Provider Information Sheet, see Appendix R-3.

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 R-201.4.

R-201.3 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 participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

R-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.

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 (address, phone, email)
- Payee demographic (address, 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 notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

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

R-202 Home Health Care Reimbursement

When billing for services, the 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 or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department bearing charges for those services or items. Co-payments are not applicable to Home Health services.

Home Health Services are paid an all-inclusive per visit rate. Reimbursement for services such as mileage and standard medical equipment/supplies are included in this rate.

Reimbursement for in–home shift nursing for children who are under 21 years of age shall be at the Department's established hourly rate to an agency licensed to provide these services.

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).

It is imperative that providers check HFS' electronic eligibility systems regularly to determine beneficiaries' enrollment in a plan. The Recipient Eligibility Verification (REV) system, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) system will identify the care coordination plan in which the participant is enrolled.

Charges for services provided to participants enrolled in a MCO or MCCN must be submitted to the MCO or MCCN. Additional information is available on the Department's website.

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.

R-202.1 Charges

Charges for the all-inclusive intermittent visit billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item.

Charges for the in-home shift nursing services are to be billed at the Department's approved hourly rate multiplied by the number of hours of service per day. If less than an hour service is provided, the Unit should be rounded up to the next hour; however the charge amount should be reduced to reflect the actual time of services. Refer to the chart in Appendix R-1, Section 28.

Refer to Appendix R-1 for detailed instructions on how to complete the form HFS 2212, Health Agency Invoice.

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.

R-202.2 Electronic Claim 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 Handbook Chapter 100 or Chapter 300.

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 Handbook Chapter 100 for further details.

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

R-202.3 Paper Claim Preparation and Submittal

Refer to Handbook Chapter 100 for general policy and procedures regarding 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. Refer to Appendix R-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scanability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

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

R-202.3.1 Claims Submittal

Form HFS 2212 (pdf) Home Health Invoice, is to be used to submit charges. Instructions for the completion of the Form HFS 2212 (pdf) are included in Appendix R-1.

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form HFS 2246, Health Agency Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use Form HFS 2248, Special Handling Envelope. A non-routine claim is any claim to which any other document is attached.

For electronic claims submittal, refer to Topic R-202.2 above. Non-routine claims cannot not be electronically submitted.

R-202.3.2 Claims Requiring Override by Department

Claims must be submitted on the paper HFS 2212, Health Agency Invoice claim form with a form HFS 1624, Override Request Form to billing staff for the following reasons:

- If a participant has Medicare Part A or Part B or both as primary payer and Medicare denies the service because the patient does not meet homebound status. In addition, the Explanation of Medicare Benefits (EOMB) or the Medicare Demand Denial should be attached to the claim. Prior approval requirements may apply. Refer to Topic R-211.

- If a participant is admitted or discharged from a long term care facility on the same day as a Home Health visit.

- If a participant resides in a residential type facility that does not receive payment to provide skilled services.

- If a participant's Medicaid eligibility is backdated, the form HFS 2212 must be submitted with a form HFS 1624, Override Request Form within 180 days of the date eligibility was approved in the system.

Claims that require an override should be mailed to:

Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, IL 62794-9115
Attn: Home Health Billing

R-202.4 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

Payment for in-home shift nursing for children less than 21 years of age shall be at the Department's established hourly rate.

R-202.5 Fee Schedule

The fee schedule of allowable Procedure Codes and special billing information is available on the Department's website. In addition, procedure codes and the intermittent reimbursement rates for each home health agency are listed on the Provider Information Sheet.

R-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.

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

Payment will be made only for home health agency services provided on an intermittent, short-term basis by a Medicare certified home health agency, a licensed community health agency or a certified health department.

Services for a participant must be provided in the individual's place of residence and aimed at facilitating the transition from a more acute level of care to the home or to prevent the necessity for a more acute level of care. A participant does not have to be homebound to qualify for home health services.

Services provided should be of a curative or rehabilitative nature and demonstrate progress toward short term goals outlined in a plan of care (POC).

Services shall be provided for individuals upon direct order of a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Advanced Practice Nurse (APN) or Physician Assistant (PA) and in accordance with a plan of care (CMS 485) established by the practitioner and reviewed by the practitioner at least every sixty (60) days.

For purposes of this section, a residence does not include a hospital or skilled nursing facility and only includes an intermediate care facility for the developmentally disabled to the extent home health services are not required to be provided under 89 Ill. Adm. Code Part 144.

In-home shift nursing care for the purposes of caring for a participant less than 21 years of age who has extensive medical needs and requires ongoing skilled nursing care must be provided by a licensed home nursing agency.

R-203.1 Home Health Care Services

Home Health Agency services include skilled nursing services; speech, physical and occupational therapy services; and home health aide services, aimed at rehabilitation and attainment of short-term goals as outlined in the plan of care.

Services must be provided in accordance with a plan of care established and approved by the attending practitioner and reviewed by the practitioner at least every sixty (60) days. Services shall be provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc., to the home environment or to prevent the necessity for a more acute level of care.

One skilled nurse home assessment visit may be made without prior approval from the Department for the purpose of assessing needs and developing a plan of care in conjunction with the attending practitioner. This visit should be billed with modifier "U2".

Skilled nursing or home health aide services following discharge of an inpatient admission at an acute care or rehabilitation hospital requiring daily visits or less within the first sixty (60) calendar days of discharge may be provided without prior approval when initiated within fourteen (14) days of discharge. If the participant's needs require more than one visit per day, prior approval is required for all the visits in the certification period.

Physical and occupational therapy visits require prior approval, regardless of age. Currently, only adults age 21 and older require prior approval for speech therapy. For all therapy disciplines, the initial therapy evaluation visit does not require a prior approval and should be billed using modifier "U2".

All Home Health services for DCFS children following discharge of an inpatient admission require prior approval. DCFS case numbers begin with "98."

All in-home shift nursing requires prior approval. Refer to Topic 211 for the prior approval requirements.

R-203.2 Definitions of Home Health Care Services

Home Assessment Visit - A service provided during the initial home visit by a registered nurse to assess the participant's condition and determine the level of care needed based on information received from the attending practitioner.

Skilled Nursing Services - Services ordered by the practitioner and are provided in a participant's home by licensed nursing personnel. Services include initiation and implementation of curative or rehabilitative nursing procedures, coordination of plan of care and patient/family instruction.

Occupational Therapy Services - Services ordered by the attending practitioner and provided to a participant by a licensed occupational therapist or licensed occupational therapy assistant under the supervision of an occupational therapist for the purpose of developing and improving the physical skills required to engage in activities of daily living.

Physical Therapy Services - Physical therapy services, ordered by a practitioner, and provided to a participant by a licensed physical therapist or licensed physical therapy assistant, under the supervision of a physical therapist. These services include, but are not limited to, range of motion exercises, positioning, transfer activities, gait training, use of assistive devices for physical mobility and dexterity.

Speech Therapy Services - Services ordered by the attending practitioner for individuals with speech disorders, and provided to a participant by a licensed speech

pathologist and/or a speech pathologist in their clinical fellowship year under the supervision of a speech pathologist for individuals with speech disorders which include diagnostic, screening, preventive or corrective services.

Home Health Aide Services - Services that are part of the treatment plan outlined by the attending practitioner and are carried out by a Certified Nurse Aide (CNA) under the supervision of a registered nurse. In those circumstances where the patient's practitioner has ordered only therapy services, the therapist (physical therapist, speech-language pathologist, or occupational therapist) may supervise the CNA. Services include the performance of simple procedures as an extension of therapeutic services; ambulation and exercise; personal care; household services essential to healthcare at home; assistance with medications that are ordinarily self-administered; and reporting changes in a patient's condition and needs to the registered nurse or therapist.

Nursing and Personal Care Services (NPCS) - Medicaid eligible participants who are under the age of 21 may receive medically necessary in-home shift nursing and personal care services provided by an RN, LPN or CNA.

Department of Children and Family Services (DCFS) In-Home Shift Nursing Program - Medicaid eligible participants who are under the age of 21 may receive medically necessary in-home shift nursing provided by an RN, LPN or CNA. Prior approval requests and required documentation must be submitted to the Department of Children and Family Services, Division of Service Intervention, Office of Health Services who will then forward to the Department for medical review and processing.

R-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 for a general list of non-covered services.

Services that are not curative or of a rehabilitative nature and do not demonstrate progress toward short term goals outline in the plan of care are not covered.

The following home health agency services are excluded from coverage in the Department's Medical Programs. Payment cannot be made for the provision of these services:

- Services ordered by terminated or barred providers
- Services which are the responsibility of local government units (e.g., city or county health Departments)
- Services for incarcerated participants
- Services of a medical social worker
- Services of a homemaker
- Prescription drugs
- May be covered through the pharmacy program
- Standard medical supplies, equipment, etc., which are not a part of the agency's per visit charge
- Non-standard medical supplies, equipment, etc., may be covered through the durable medical equipment program
- Routine care of the newborn
- Routine post-partum care
- Infant stimulation
- Infant/mother bonding/parenting skills
- Similar services provided by more than one home health agency
- Services that are no longer acute, rehabilitative or restorative
- A visit to obtain information for the purpose of recertification
- Palliative services for participants age 21 and older
- Respite hours in the NPCS program
- One-on-one nursing hours provided in the school setting
- Care provided by a legally responsible relative of the child 18 years of age or younger
- Visits when the sole purpose is to prefill pill organizers (medbox refills)
- Visits when the sole purpose is to prefill insulin syringes
- Intermittent nursing visits for the sole purpose of obtaining a blood sample

If the participant is in need of homemaker or social services, the agency may contact the Department of Human Services' Division of Rehabilitation Services office. A determination should be made for a hospice if palliative care is needed.

Conditionally Covered
Care that does not require the professional skill of a nurse is not normally covered. Exceptions are considered when medically necessary in view of the patient's overall condition.

A home health agency will not be reimbursed to provide services to a resident in a Supportive Living Facility (SLF) if the service is offered by the SLF.

R-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.

Providers of intermittent home health services and in-home shift nursing must maintain records in compliance with the requirements set forth in 77 Ill. Admin. Code Part 245 and, if applicable, the University of Illinois, Division of Specialized Care for Children Guidelines for Nursing Agencies.

The minimum record requirements satisfying Department standards for home health services are as follows:

- Identification of the participant, i.e., name and address, case identification number, age
- Complete and current diagnosis
- Name of ordering practitioner (orders from an MD, DO, APN or PA)
- 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
- Copy of practitioner orders and treatment plan (CMS 485/POC) for each sixty (60) day certification period and sixty (60) day summary for recertification
- Copy of prior authorization request, when applicable
- Therapy evaluation for initial visits and therapy progress reports for recertification that document progress toward treatment goals

In the absence of proper and complete medical records, payment will not 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.

R-205.1 Face-to-Face Encounter Requirements

The following conditions must be met for the face-to-face encounter:

- The certifying physician must document that the face-to-face encounter is related to the primary reason the patient requires home health services. The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care. The

certification must include the date of the encounter, and an explanation of clinical findings that support the patient's need of either intermittent skilled nursing services or therapy services.

- The face-to-face encounter must be performed by the certifying physician; a nurse practitioner or a clinical nurse specialist who is working in collaboration with the physician in accordance with State law; a certified nurse midwife as authorized by State law; a physician assistant under the supervision of a physician; or for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility. The documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated, and signed by the certifying physician.

- If the certifying physician does not perform the face-to-face encounter personally, the non-physician practitioner or the physician who cared for the patient in an acute or post-acute facility who performed the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the certifying physician. The certifying physician has the discretion on what type of communication they will accept from the practitioner who completed the actual face-to-face encounter. The certification must be clearly titled, dated, and signed by the certifying physician.

- If a face-to-face patient encounter occurred within 90 days prior to the start of care but is not related to the primary reason the patient requires home health services, or the patient has not seen the certifying physician or allowed non physician practitioner within the 90 days prior to the start of the home health episode, the certifying physician or non-physician practitioner must have a face-to-face encounter with the patient within 30 days after the start of the home health care.

- The face-to-face encounter may occur through telehealth.

- The face-to-face certification is not considered a separate allowable service and will not be separately reimbursed to practitioners if billed.

- Providers must submit documentation of the face-to-face encounter with the Plan of Care for services that require prior approval. Providers must maintain documentation of the face-to-face encounter in the participant's record regardless if the service requires prior approval.

- The face-to-face encounter requirement does not apply to re-certifications or services provided by a home health aide.

R-211 Prior Approval Process

Prior to the provision of certain services, approval must be obtained from the Department.

If charges are submitted for services that require prior approval and approval was not obtained, the claim will be rejected. 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 patient's eligibility on the date of service. 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.

A request for prior approval must be submitted in advance in order to maintain continuity of services. Refer to Chapter 100 for a general discussion of prior approval provisions.

Prior approval requirements do not apply to skilled nursing and home health aide services for the first 60 days following an inpatient hospital discharge, if start of care begins within 14 days of an inpatient discharge date from an acute care or rehabilitation hospital.

Prior approval must be requested for participants who:

- Are in need of any Physical or Occupational Therapy
- Are 21 years of age or older and in need of Speech Therapy
- Require continuation of services after the initial sixty (60) calendar day period following hospital discharge
- Require continuation of services beyond the initial approval period
- Have exhausted Medicare benefits
- Are eligible for Medicare benefits, but the service is determined non-covered by Medicare for reasons other than homebound status
- Have primary insurance coverage that will pay a portion but a balance is still remaining
- Require more than one skilled nurse visit per day. When requesting prior approval, please request the total number of visits that will be provided during the certification period
- Require home health services following a hospital discharge and who have a DCFS Medicaid case number beginning with "98"

- Require in-home shift nursing

All requests for prior approval must contain a copy of the most current plan of care (CMS 485/ (POC)) for the time period requested.

R-211.1 Intermittent Nursing Services

Prior approval requests for intermittent nursing services must contain the following:

- Prior Approval Request, Form HFS 1409 (pdf)
- Current signed and current dated plan of care (CMS 485 (pdf)/POC)
- Documentation of the face-to-face encounter (Refer to Topic R-205.1)
- Addendum order, if applicable
- Copy of the initial evaluation or progress summary for therapy services.
- Recertification requests must include the sixty (60) day summary
- A copy of the OASIS is not required and will not be accepted as the sixty (60) day summary

R-211.2 In-home Shift Nursing Services for Participants Under 21 Years of Age

For in-home shift nursing services, approvals will be granted for the first and second sixty-day certification periods. Upon the third submittal for re-certification a six-month approval may be granted after the medical review process is completed. For ongoing in-home shift nursing services a six-month approval may be granted after medical review. The Department reserves the right to reduce the approval certification time period when medically appropriate.

Initial Requests require the following documentation:

Letter of Medical Necessity, which must include:

- Health history
- Social history
- Identification of the need for services per discipline – RN, LPN or CNA
- Number of nursing hours and level of service (RN, LPN or CNA) requested per day
- List of available caregivers
- If the child is currently in a hospital or facility, a comprehensive hospital summary and/or discharge summary
- If the child is currently at home, all available primary care physician or specialist office notes
- Assessment of Need for Care
    - Child's name, date of birth, and recipient number
    - Primary Care Physician
    - Discharging Facility (specify if it is a hospital or institution)
    - Diagnosis
    - Current Medications
    - Nutrition and delivery mode (e.g., BOLUS, Continuous, Central Line, Pump)

    - Review of body systems (e.g., respiratory, cardiovascular, gastrointestinal, musculoskeletral, genitourinary, sensory, integumentary, neurological, endocrine and psychiatry)
    - Therapy needed
- Identify the number of children in the home and if any are receiving nursing services.
- If the child is attending school, whether or not there is an IEP in place and identify if one-on-one nursing is required at school.
- If the request is submitted by the Department of Children and Family Services (DCFS), it must identify whether the child is a ward, or has an adoption assistance or subsidized guardianship agreement.
- If the child has an adoption assistance or subsidized guardianship agreement, a copy of the agreement must be submitted. The copy may be redacted.

Renewal Requests require the following documentation:

- Current signed plan of care CMS 485 (pdf)
- Prior Approval Request, Form HFS 1409 (pdf)
- Ten (10) days of nursing notes
- Nursing Supervisory Summary DSCC 55.08
- Requests may be submitted fourteen (14) days prior to expiration of the current approval
- Identify the number of children in the home and if any are receiving nursing services

The Department approves in-home shift nursing hours that are medically necessary for the child's care. Any one-on-one nursing hours provided in the school setting indicated in the child's Individualized Education Program (IEP) must be deducted from the total number of approved weekly hours. This information must be indicated in the child's plan of care CMS 485 (pdf)/POC) when submitting a prior approval to the Department. Prior approval will be granted for the total number of hours approved, however, HFS may only be billed for hours provided in the home setting.

Effective with dates of service January 1, 2016, prior approval issued for in-home shift nursing services represents the total number of approved hours for the specified timeframe approved and a total amount that represents the approved hourly rate.

When more than one child in the home is receiving hourly care, the Department will review each child's medical needs to determine the most cost effective coverage (e.g., 1 nurse: 2 kids).

Respite hours are not covered by the Department.

R-211.3 Approvals for Long Term Need

At the Department's discretion, the following services provided on an intermittent basis may be given approval periods beyond sixty (60) days.

- Urinary catheter maintenance - up to two (2) visits monthly for six (6) months
- Vitamin B 12 injections – one (1) visit per month for six (6) months
- Maintenance of central access devices (e.g., mediport, portacath) – one (1) visit per month for six (6) months
- Synagis injections – Please refer to the pharmacy guidelines located on the Department's website
- Baclofen Pump Refills – up to two (2) visits monthly for six (6) months

The Department will review the CMS 485 (pdf)/POC to verify the number of visits the practitioner ordered and will approve lesser amounts if applicable. If an agency provides additional visits during the above listed periods, a paper review with an addendum order to cover the additional visits must be submitted.

R-211.4 Prior Approval Requests

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

The provider is to complete the Form HFS 1409 (pdf) when requesting prior approval. Instructions for completion of Form HFS 1409 (pdf) are located in Appendix R-2.

All HFS 1409 (pdf) forms must be signed in ink by the provider or designee.

The most common reason for denial of prior approval requests is lack of adequate information to make a decision.

The exact information needed will vary depending on the service requested and the medical condition of the patient, but the process described below is designed to cover the general information needed for all requests.

Prior approval requests may be submitted to the Department by mail, fax, or in an emergency by telephone.

By Mail:

The signed copy of the Form HFS 1409 (pdf) and other associated documentation listed in Topic R-211.1 may be mailed to

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Office Box 19124
Springfield, Illinois 62794-9124

By FAX:

The signed copy of the Form HFS 1409 (pdf) and other associated documentation listed in Topic R-211.1 may be faxed to the number shown below. Providers should review the documents before faxing to ensure they will be legible upon receipt. The fax number for initial and renewal prior approval requests is 217-524-0099. The fax number for providers supplying additional information to HFS staff for review of a prior approval request that was previously submitted is 217-558-4359. Both fax numbers are available Monday through Friday, 8:30 AM – 5:00 PM, except holidays.

R-211.5 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.

R-211.6 Denial of Service

If the service requested is denied, a computer-generated Form HFS 3076C, citing the denial reason, will be mailed to the patient and the provider. The provider cannot file an appeal of the denial. 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.

R-211.7 Change in Prior Approval Status

Home health approvals are not transferable. They are specific to a recipient identification number and to a specific provider number/NPI.

If approval has been obtained and corrections are needed on the approval dates or approved quantity, the provider must submit a review request within 90 days of the approval notification. The provider may note the corrections on the approval notice (HFS 3076) and fax the information to the prior approval unit's review fax at 217-558-4359. The Department will mail a revised approval notification when the update has been completed. Cancellations can also be directed to the review fax line at 217-558-4359. Requests by telephone to change prior approvals will not be accepted.

If a patient is admitted to the inpatient hospital setting within the approved date ranges of service, the Department must be notified in writing to end the prior approval on the date of admission.

R-211.7.1 Transfer from One Agency to Another

Patients are entitled to a choice of providers and may choose to change providers. The Department may request verification that the patient chose to make the change. HFS requires a cancellation statement from the former provider to end a prior approval. The new provider can then submit a prior approval request with their name and provider number/NPI with the medical documentation.

Example – patient receives services from ABC Agency but is now transferring to DEF Agency. ABC Agency needs to submit a cancellation statement to the Department.

R-211.7.2 Recipient Identification Number Change

If a participant's recipient identification number changes, then the provider must cancel the approval under the former identification number. The provider must then submit a corrected Form HFS 1409 (pdf), with the new recipient number and medical documentation.

R-211.7.3 Buy-out/Change in Ownership Procedures

When a company buys out another company's interest in services that require prior approval, HFS considers it a buy-out. Effective with the date of the company's purchase, the new provider will need to bill all services with their NPI/Provider Number. The company that was sold cannot bill or be reimbursed for any dates of service after the enrollment end date. The new company cannot bill for services with the NPI/Provider Number of the purchased company for dates prior to the enrollment effective date; therefore, all the prior approvals with the purchased company's NPI/Provider Number that extend beyond the company's end date must be changed.

The following instructions are to change the prior approvals from the purchased company to the new company:

1. A letter from the new company to HFS should be sent with the following information:

    - The old provider name, NPI/Provider number, and the effective end date
    - The new provider name, NPI/Provider number, and the effective enrollment date

2. Copies of the purchased company's original Prior Approval Notification Letter, HFS 3076A:

    - The quantity amount should be changed to the actual amount used through the effective end date of enrollment.

3. A new Prior Approval Request Form, HFS 1409 (pdf), for each prior approval with the new company's information and the balance of the visits not provided. The begin date should be from the effective date of enrollment and the end date should be the same as the original prior approval end date.

    - HFS will not approve any services past the original approval date
    - All prior approval changes must be submitted at one time in one buy-out packet

- The changes must be submitted within 30 days of notifying the Department
- All changes that are not submitted in the initial packet will not be processed

The completed packet can be mailed to the following address:

HFS, BPAS, Buy-Out
P.O. Box 19124
Springfield, IL 62794-9124

Questions should be directed to the Prior Approval Supervisor at 217-524-0009.

Providers have 90 days from the date of enrollment to submit the packet to the Prior Approval Unit for review. If received beyond the 90 day timeframe, the prior approvals will be considered untimely and returned to the provider unprocessed.

R-211.8 Timelines

The Department is obligated to make a decision on prior approval requests within specified time frames. In general, decisions must be made within twenty-one (21) days of receipt of a properly completed request, with exceptions as described below. If a decision has not been made within the twenty-one (21)-day period, the service is automatically approved. 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 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 twenty-one (21)-day period stops. When the required information is received, a new twenty-one (21)-day period begins.

The provider can request status of a prior approval after thirty (30) days from the Department's receipt date. This can be done by calling the prior approval unit at 1-877-782-5565, Option 5.

R-211.9 Post Approvals

To be eligible for post approval consideration, all the normal requirements for prior approval of the service must be met, and the post approval requests must be received by the Department no later than ninety (90) days from the date services are provided or within the time frames identified in 211.8.

When requesting post approval for home health visits, the Department requires documentation indicating the dates the visits were completed during the requested

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

- Determination of the patient's eligibility for any of 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 ninety (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 service and those third parties denied payment after the service was provided. To be considered under this exception, documentation that the provider billed a third party payor 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 ninety (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 programs. In such a case, the post approval request must be received no later than six (6) 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.