HFS MANAGED CARE BILLING AND GUIDELINES:
Home and Community-Based Services (HCBS) Waiver Providers
8/7/2020

The purpose of this update is to outline policy and procedure billing changes for HCBS Waiver providers.

The billing guidance will ***REPLACE*** any previously issued billing guidance for these providers for any claims received starting 11/1/2020. Providers should continue billing MCOs with current practices until that time. The guidance can be found on the following pages.

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Home and Community Based Health (HCBS) Waiver Providers

a. Purpose

MCOs have implemented updated standard claims submission processes to be utilized for the reimbursement of services rendered by certified and enrolled Home and Community Based Services (HCBS) Waiver providers. As required by the Illinois Department of Healthcare and Family Services (HFS), HCBS Waiver providers are eligible to render covered services and must adhere to the following prescribed billing criteria to be reimbursed accordingly by MCOs.

Services Overview

The State of Illinois offers services and programs that allow members to be independent while continuing to remain in their homes. Home and Community Based Services (HCBS) may also be referred to as "waivers." This is a collaborative effort between the Illinois Department on Aging (IDoA), the Department of Human Services/Division of Rehabilitation Services (DRS), the Department of Healthcare and Family Services (HFS) and is administered by the Managed Care Organizations (MCO's).

The State determines a member's eligibility for these service programs by performing an assessment called the Determination of Need (DON). The DON is used to analyze and score the member's level of need. This scoring is the basis for the member's service plan.

There are five different waiver programs the MCO administers and for which the providers of service bill for reimbursement:

Persons who are Elderly- Elderly Waiver:
The Illinois Department on Aging (IDoA) operates this waiver population for person age 60 or older, who are otherwise eligible for or at risk for nursing facility care as evidenced by a DON.

Person with Disabilities Waiver:
The Department of Human Services/Division of Rehabilitation Services (DRS) operates this waiver population for persons (age 0-59) with disabilities (those 60 or older, who began services before age 60, may choose to remain in this waiver). MCO waiver eligibility requirements are that the member has a severe disability which is expected to last for at least 12 months or for the duration of life, and eligible for or at risk for nursing facility care as evidenced by the DON.

Person with HIV or AIDs Waiver:
DRS administers this waiver population for persons of any age diagnosed with HIV or AIDS who are at risk of . hospital or nursing facility care as evidenced by the DON.

Persons with Brain Injuries (BI) / Traumatic Brain Injury (TBI) Waiver:
DRS administers this waiver population for persons of any age with brain injury; have functional limitations directly resulting from an acquired brain injury, including traumatic brain injury, infection (encephalitis, meningitis),
anoxia, stroke, aneurysm, electrical injury, malignant or benign, neoplasm of the brain, and toxic encephalopathy; have a severe disability which is expected to last for at least 12 months or for the duration of life, and are risk of placement in a nursing facility as evidenced by the DON.

Supportive Living Program - SLP Waiver:
The Illinois Department of Healthcare and Family Services (HFS) operates this waiver population for persons ages 65 and older, or persons with disabilities (as determined by the Social Security Administration) age 22 and older. Individuals have been screened by HFS and found to be in need of nursing facility level of care and it is determined that a SLF is appropriate to meet the needs of the individual. Individuals must not have a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. Finally, an individual's income must be equal to or greater than current SSI and they must contribute all but $90 toward lodging, meals, and services. Food stamp benefits may be used toward meal costs.

Note: Refer to the IAMHP Billing Manual section for SLP providers.

HFS identifies individuals who are eligible for waivers on the 834 enrollment files that they share with the MCO's, in addition to the workflows set up directly with IDoA, the Care Coordination Units (CCU's) and DRS.

b. Provider Type, NPI, Other Identifiers and Taxonomy Codes

The following HFS Provider Types are consider HCBS Waiver Providers that can be billed to an MCO:

HFS Provider Type	HFS Description
090	Waiver service provider--Elderly (IDoA)
092	Waiver service provider--Disability (DHS/DRS)
093	Waiver service provider--HIV/AIDS (DHS/DRS)
098	Waiver service provider--TBI (DHS/DRS)

To file a claim for services that an MCO has approved for one of the five HCBS waivers described above, waiver providers are required to register as a Waiver provider with IMPACT. Many HCBS providers are considered 'atypical' by HFS' IMPACT system. HFS IMPACT Definition of an 'Atypical' provider is:

A provider who is delivering services to Medicaid clients that are not considered to be health care services. These providers are not required to obtain an NPI (National Provider Identifier). The Centers for Medicare and Medicaid Services (CMS) defines Atypical Providers as providers that do not provide health care. This is further defined under HIPAA in Federal regulations at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of Atypical Providers reimbursed by the Medicaid program. Even if these Atypical Providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and should not receive an NPI number.

When billing HCBS services, the provider should only use their HFS' Legacy Provider Number (Medicaid ID) and should NOT send in an NPI on the claim.

MCOs will require that the HFS' Legacy Provider Number (Medicaid ID) on the claim matches the IMPACT Legacy Provider Number (Medicaid ID). MCOs will not process the claim if the Legacy Provider Number (Medicaid ID) used does not match the corresponding HFS' Legacy Provider Number (Medicaid ID) and IMPACT-registered categories of service, specialties etc. The provider's HFS Legacy Provider Number (Medicaid ID) must match the

IMPACT-registered provider type that corresponds with the member's waiver type. For example, an HFS' Legacy Provider Number (Medicaid ID) registered as provider type 090: Waiver service provider—Elderly should not be billed on a claim for a member who has a TBI waiver.

A valid Medicaid ID must be on the 837P Billing Provider Secondary Identification Loop 2010BB Loop in a REF01 Segment qualified by 'G2' and the REF02 equal to the provider's Medicaid ID as registered in IMPACT for their respective waiver provider type.

If the provider has multiple registrations with HFS for provider types outside of the HCBS service realm, the provider should ONLY bill their NPI on the claim for **NON-HCBS** services.

For example, if the provider is registered as an HFS Home Health provider type (050) and registered as a HCBS service provider (090), when billing for Home Health services the provider will bill on an 837I and must use their NPI in the 2010AA Billing Loop on the 837I. When billing as HCBS with HFS provider type 090, the claim must be on an 837P and the provider must submit their Medicaid ID *without* an NPI.

Personal Assistants and Individual Providers

The MCO's work in collaboration with the member to develop an individualized care plan that may include personal assistants. The MCO's will provide care coordination and oversight of the services being provided to the member. Personal Assistants (PA's) and Individual Providers (IP's) that are not working through an agency are required to enroll in IMPACT. When seeking reimbursement, PA and IP's will not submit claims directly to the MCO's. They will be required to log their time using the electronic visit verification system and from there, the payment will be issued by the State of Illinois.

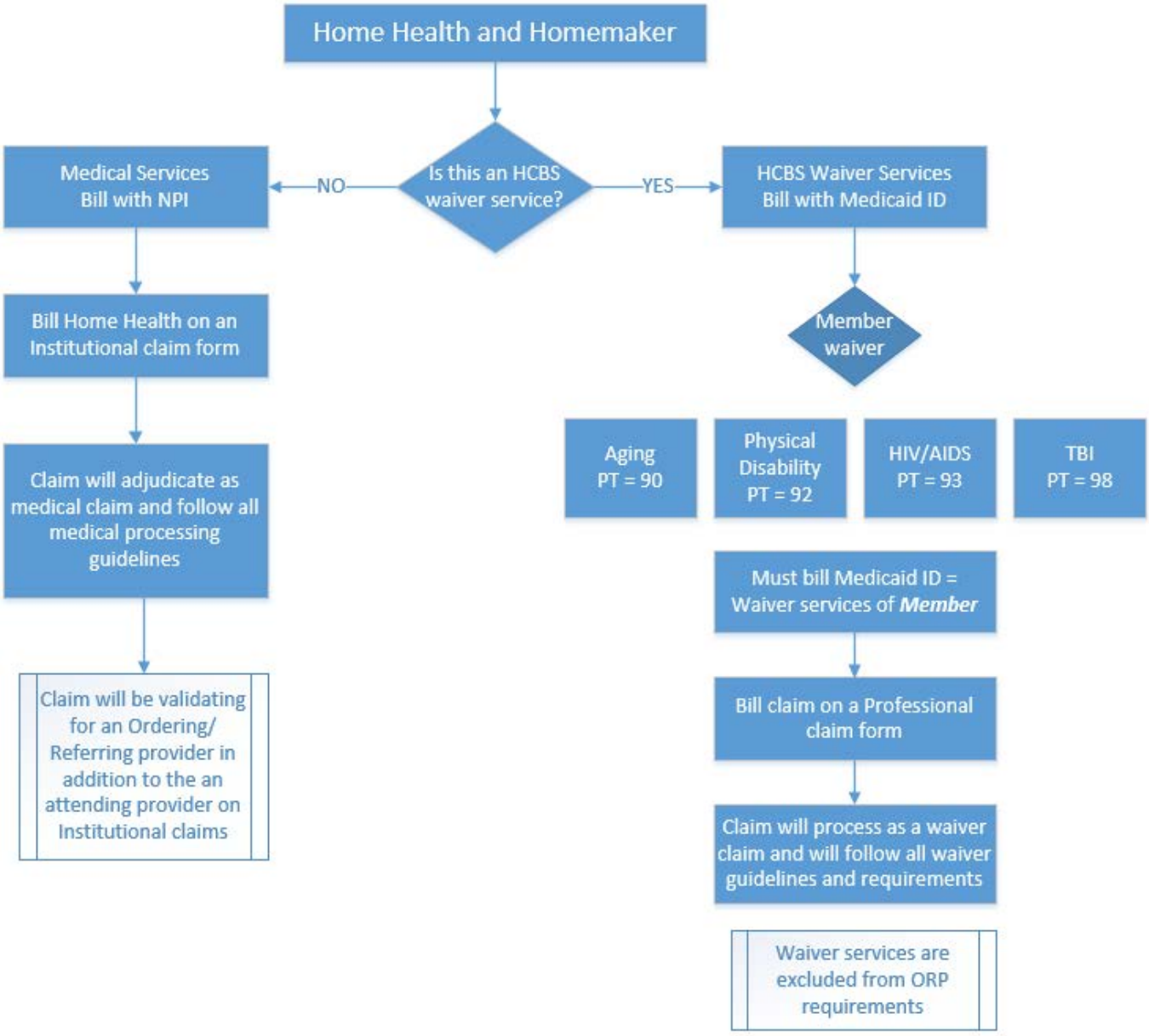
Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to a MCO, the specialties and subspecialties registered in the HFS Provider IMPACT system are critical to accurate claims payment. If the appropriate specialty or subspecialties are not registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by HFS.

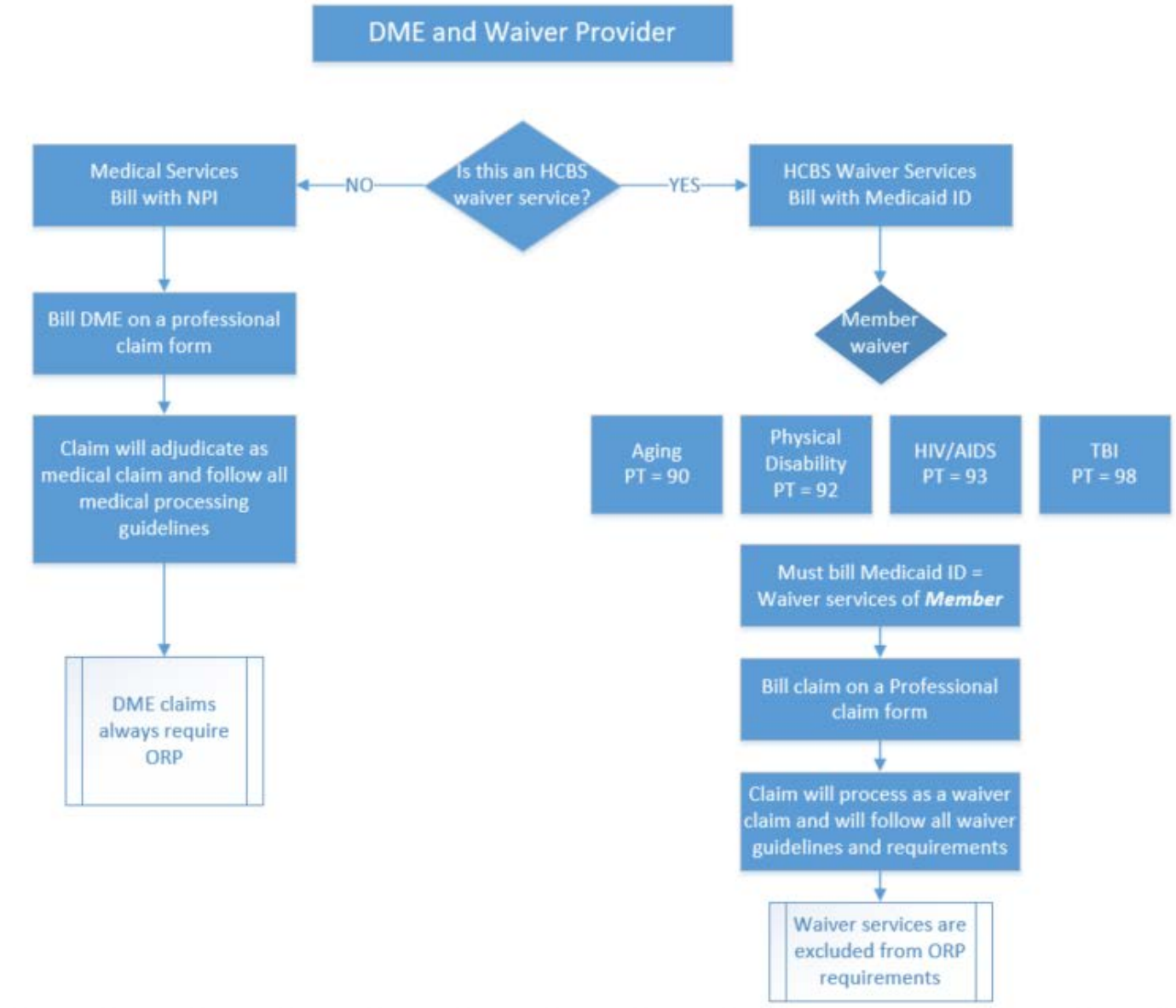
HFS Legacy Category of Service	IMPACT Subspecialty
090	Case Management
091	Home Maker
092	Agency Providers PA, RN, LPN, CAN and Therapist
093	Individual Providers PA, RN, LPN, CAN and Therapist
094	Adult Day Service
095	Habilitation Services
096	Respite care
097	Other HCFA approved services
098	Electronic Home Response/EHR installation

Diagram -

Example 1: Provider who is registered in IMPACT as both a Home Health Provider and as a Waiver Provider



Example 2: Provider who is registered in IMPACT as a DME Provider and a Waiver Provider



General Claims Submission Requirements:

- Services should be billed on a CMS 1500 or an 837P electronic format. For minimum claim requirements and timely filing deadlines for Plans, see Introduction - Minimum Claim Requirements.
- It is the responsibility of the provider to ensure compliance with all the service requirements of a recipient's payer, including service notifications or prior authorizations. Prior to providing Waiver services, providers should reference the MCO Provider Agreements for information on service requirements. A crosswalk of the prior authorization requirements of each of the HFS contracted Managed Care Plans can be found on in the IAMHP Comprehensive Billing Guide. Providers that do not comply with the service requirements of a recipient's payer may be subject to claims denial.

The following procedure codes and taxonomies are to be used for billing services by Provider type and service:

Coding Requirements

HCSB Service	HCPC Procedure Code	Modifier	Unit Value Definition	Allowable Place of Service	Elderly Waiver HFS Provider Type: 90	Disability Waiver HFS Provider Type: 92	HIV/AIDS Waiver HFS Provider Type: 93	Traumatic Brain Injury Waiver HFS Provider Type: 98	HFS Category of Service/ Specialty/Subspecialty	Acceptable Taxonomies
Homemaker	S5130		15 minutes 1 hour = 4 units	12	Y	Y	Y	Y	91	376J00000X--Homemaker 251E00000X--Home health
Agency Services C N A	T1004		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care
Adult Day Care	S5100		15 minutes 1 hour = 4 units	11, 99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care
Adult Day Care Transportation	T2003		1 unit is 1 trip maximum of 2 daily	99	Y	Y	Y	Y	94	261QA0600X--Adult Day Care
Respite Adult Day Care	T1005	HQ	15 minutes 1 hour = 4 units	99		Y	Y	Y	96	261QA0600X--Adult Day Care 385H00000X--Respite Care
Respite Adult Day Care Transportation	T1005	HB	1 unit is 1 trip maximum of 2 daily	99		Y	Y	Y	96	261QA0600X--Adult Day Care 385H00000X--Respite Care
Respite Agency Services Home Health Aide (CNA)	T1005	SC	15 minutes 1 hour = 4 units	12		Y	Y	Y	96	385H00000X--Respite Care 376J00000X--Homemaker 251E00000X--Home Health
Respite Homemaker	T1005	SE	15 minutes 1 hour = 4 units	12		Y	Y	Y	96	385H00000X--Respite Care 376J00000X--Homemaker
Respite Agency Services LPN	T1005	TE	15 minutes 1 hour = 4 units	12		Y	Y	Y	96	385H00000X--Respite Care 376J00000X--Homemaker 251E00000X--Home Health
Respite Agency Services RN	T1005	TD	15 minutes 1 hour = 4 units	12		Y	Y	Y	96	385H00000X--Respite Care 376J00000X--Homemaker 251E00000X--Home Health
TBI Day Habilitation	T2020		Per Diem 1 day = 1 unit	11, 99				Y	95	261QR0400X--Specialized Rehabilitation 373H00000X--Day Training Habilitation Specialist 251E00000X--Home Health
Prevocational Services	T2014		Per Diem 1 day = 1 unit	11, 99				Y	95	251S00000X--Community/Behavioral Health 251E00000X--Home Health

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Supported Employment No Job Coach Individual	T2019		1 unit = 1 hour	11, 99				Y	95	251S00000X--Community/Behavioral Health 261QR0400X--Specialized Rehabilitation 251E00000X--Home Health
Home Modification	S5165		Varies with services Maximum of $25,000.00 in a five-year period	12		Y	Y	Y	97	171WH0202X--Home Modifications 171W00000X--Contractor
Specialized Medical Equipment/Supplies Purchase	T2028		Varies with services Maximum of $25,000.00 on a five-year period	12, 99		Y	Y	Y	97	332B00000X--Medical Equipment & Medical Supplies
Specialized Medical Equipment/Supplies Rental	T2028	RR		12, 99		Y	Y	Y	97	332B00000X--Medical Equipment & Medical Supplies
Agency Services-Individualized service provided to more than one patient in the same setting	T1002	TT	15 minutes 2 hour = 8 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
Agency Services LPN	T1003		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
Agency Services RN	T1002		15 minutes 1 hour = 4 units	12		Y	Y	Y	92	251E00000X--Home Health 251J00000X--Nursing Care 282N00000X--General Acute Hospital 253Z00000X--In Home Supportive Care
Behavioral Services Master's Degree Level (MA)	H0004	HO	Per visit with a 2-hour maximum	11, 12				Y	97	251S00000X--Community/Behavioral Health
Behavioral Services Doctoral Level (PHD)	H0004	HP	Per visit with a 1-hour max	11, 12				Y	97	251S00000X--Community/Behavioral Health
Physical Therapy	G0151		15 minutes 1 hour = 4 units Maximum = 4 hours per day	11, 12		Y	Y	Y	97	225100000X--Physical Therapist 251E00000X--Home Health

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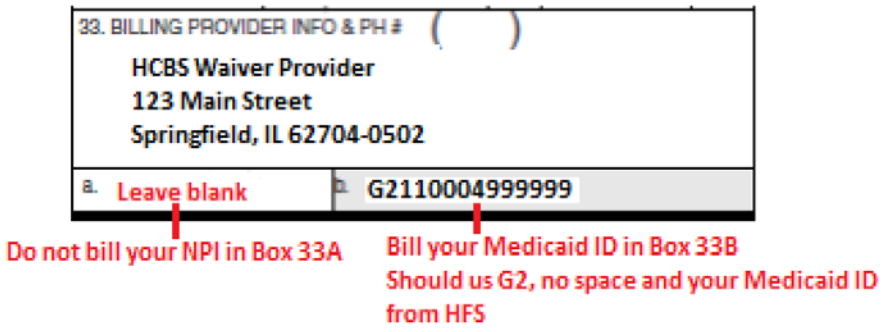
Occupational Therapy	G0152		15 minutes 1 hour = 4 units Maximum = 4 hours per day	11, 12		Y	Y	Y	97	225X00000X--Occupational Therapist 251E00000X--Home Health
Speech Therapy	G0153		Per visit with a 4 hours max	11, 12		Y	Y	Y	97	235Z00000X--Speech Therapist 251E00000X--Home Health
Speech Therapy-Services delivered under an outpatient hospital speech language pathology plan of care	G0153	GN	Per visit	11, 19, 22		Y	Y	Y	97	235Z00000X--Speech Therapist 282N00000X--General Acute Hospital
Home Delivered Meals	S5170		2 meals = 1 unit Maximum = 1 unit per day	12, 99		Y	Y	Y	97	332U00000X--Home Delivered Meals
Personal Emergency Response Install	S5160		Per Install	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 3333300000X--Emergency Response System
Personal Emergency Response Monthly	S5161*	*	Per Month	12, 99	Y	Y	Y	Y	98	146D00000X--Personal Emergency Attendant 333300000X--Emergency Response System
Automatic Medication Dispenser	A9901		Per Install	12, 99	Y				98	332B00000X--Medical Equipment & Medical Supplies
Automatic Medication Dispenser Monthly	T1505		Per Month	12, 99	Y				98	332B00000X--Medical Equipment & Medical Supplies

***Exception for Molina: When services are provided on a cellular platform vs. a landline, S5161 should include the U2 modifier.**

837P Submission Guidelines:

Paper Claim CMS-1500	HIPAA 5010 837P Loop	HIPAA 5010 837P Segment	Waiver Reimbursement
Box 24b	2300	CLM05-1	Place of Service Code
Box 24f	2400	SV1-02	Appropriate procedure code as indicated in the coding grid above
Box 24j	2310B	NM1-09	Should not submit
Box 31	DOES NOT MAP IN THE 837	DOES NOT MAP IN THE 837	
Box 32	2310C	NM1	Service Facility Location Information
Box 33	2010AA	Do not send NPI in NM109 – See 2010BB Loop below	Registered HCBS Organization Name, billing address, HFS Medicaid ID, and applicable taxonomy (as registered in IMPACT). Per X12 EDI guidance NO P.O. Boxes or LOCK box permitted in this loop (2010AA)
Box 33B	2010BB	REF02 = G2 REF03 = Provider's HFS Medicaid ID	HFS Medicaid ID for provider Example 2010BB example: REF*G2*Provider HFS Medicaid ID Paper Example 
Pay to Provider **No field for this on CMS 1500**	2010AB	NM1*87	Pay to Provider Address (P.O. Box or Lock Boxes acceptable in this loop) **

** FOR MOLINA: Pay to Provider address must exactly match the name provided on W-9 documents. If clinic uses a 3rd Party biller to receive payments, that address must be on the W9, and the vendor must be listed as a DBA.