Illinois Health and Hospital Association

Notice of Assessment

The Illinois Dept. of Healthcare and Family Services (HFS) released a notice to inform hospitals that are subject to the inpatient and outpatient assessments imposed on Illinois hospital inpatient and outpatient services under of 305 ILCS 5/5-A. HFS mailed the calculations and the remittance notices for the fiscal year 2019 inpatient and outpatient program. Below are the dates the assessments are due to avoid any penalties.

July-18	August 2, 2018
August-18	August 20, 2018
September-18	September 21, 2018
October-18	October 19, 2018
November-18	November 26, 2018
December-18	December 20, 2018
January-19	January 22, 2019
February-19	February 22, 2019
March-19	March 20, 2019
April-19	April 18, 2019
May-19	May 20, 2019
June-19	June 20, 2019

Changes to Hospital Inpatient and Outpatient Reimbursement Systems Effective with Dates of Service on and after July 1, 2018

HFS issued a notice regarding the claims based rate increases and policy adjustors that are effective for inpatient discharges and outpatient dates of service on and after July 1, 2018. These reimbursement changes do not affect any claim completion instructions. Hospitals can access their updated rate sheet here. See the notice for more details.

Updated Pricing Calculators

New inpatient and outpatient pricing calculators, updated to include reimbursement changes effective July 1, 2018, have been posted to the Department's website.

Clarification Regarding Use of Modifier 90 [Reference (Outside) Laboratory] for Hospital Outpatient Claims Billed on the 837P or HFS 2360 Claim Formats

HFS issued a notice in response to inquiries related to the February 13, 2018 Informational Notice to hospitals and laboratories regarding reference laboratory services. The HFS billing requirement for modifier 90 [Reference (Outside) Laboratory] is only pertinent to non-Ambulatory Procedures Listing lab services billed using either the 837P or HFS 2360 claim format. It does not apply to the institutional UB-04 or 837I claim formats. If a hospital is billing for the global service (professional and technical components) because a reference lab completed the service, modifier 90 must be used; otherwise, modifier 90 should not be used.

For laboratory services in the hospital outpatient setting, hospitals may bill for the technical component when the hospital obtains the specimen and completes the test. The claim for the professional services of the pathologist, whether or not the pathologist is salaried by the hospital, must be submitted under the name and NPI of the pathologist.

The Department extended the effective date for hospitals to comply with the modifier requirement to June 1, 2018, to allow more time for hospitals and MCOs to update their processing systems. See the HFS memo.

Chapter L-200, Handbook for Providers of Laboratory Services
Correction Regarding Global Laboratory Billing in the Hospital Outpatient Setting and Hospital Use of Modifier 90 for Reference Laboratory Services
HFS released a notice that corrects information contained in Topic L-210.1.2 regarding HFS 2360 billing for laboratory services.

In the hospital outpatient setting, the professional component of laboratory services must be billed under the name and NPI of the physician who performed the service, whether or not that physician is salaried. The hospital may not bill the global service. Hospitals may only bill the global service for lab tests performed in a reference laboratory and must identify those reference lab services using modifier 90.

Topic L-210.1.2 has been revised to reflect the accurate billing instructions. Click here for the instructions for updating the Handbook for Provider Services.

Standardized Medicaid MCO “Provider Roster” Template
HFS issued a notice to inform providers about the launch of a standardized “provider roster” format. As part of an industry collaborative effort, the HFS, the Illinois Association of Medicaid Health Plans , Illinois Medicaid Managed Care Organizations (MCOs), and the IHA, are pleased to announce the launch of a standardized “provider roster” format.

Providers should use the standardized provider roster when submitting information to Medicaid MCOs as required for claims payment, care coordination and directory purposes. The collaborative efforts balance the needs of MCOs in collecting specific data not accessible through the HFS IMPACT verification system. Centers for Medicare & Medicaid Services rules also require providers to utilize a more efficient process and singular provider roster format applicable to all Medicaid MCOs. Refer to the HFS notice for important points to remember.