



Handbook for Providers of Medical Equipment and Supplies

Chapter M-200 Policy and Procedures For Medical Equipment And Supplies

Illinois Department of Healthcare and Family Services

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Chapter M-200

Durable Medical Equipment and Supplies

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Foreword

Purpose

This handbook has been prepared for the information and guidance of durable medical equipment and supplies (DME) providers that provide items or services to participants in the department's Medical Programs. It also provides information on the department's requirements for provider participation and enrollment.

This handbook provides information regarding specific policies and procedures relating to DME services. It is important that both the provider of service 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 in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the department's Medical Programs. The updates will be posted to the department's [Provider Releases and Bulletins](#) page.

Providers will be held responsible for compliance with all policy and procedures contained herein. Providers wishing to receive [e-mail notification](#), when new provider information has been posted by the department, may register on the website.

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

Chapter M-200

Durable Medical Equipment Medical Supplies

M-200 Basic Provisions

For consideration of payment by the department for medical equipment or medical supply items, a provider enrolled for participation in the department's Medical Programs must provide such services. Services provided must be in full compliance with both 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 are specific to the department's paper forms and apply to patients 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). Further information can be found at the [HFS Care Coordination website](#).

DME providers billing the services described in this handbook use the HFS 2210 claim form (or for Medicare crossover claims, the HFS 3797) for billing paper claims. Providers submitting X12 electronic transactions must refer to [Chapter 300](#), Handbook for Electronic Processing, found on the department's website.

Chapter 300 identifies information that is 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.

M-201 Provider Enrollment

M-201.1 Enrollment Requirements

Eligible providers are those who supply or service nondurable medical supplies, durable medical and respiratory equipment, prostheses, orthoses, oxygen and hearing aids.

In order to be eligible for reimbursement for dispensing certain specialized medical devices or items, a provider must be licensed or exempt from licensure under the Home Medical Equipment and Services Provider License Act, 225 ILCS 51. Providers located in other states must also be in compliance with the appropriate licensing or accreditation requirements of their state of practice.

Audiologists who dispense hearing aids, Long Term Care (LTC) facilities that dispense oxygen and hospitals should consult their respective handbooks for enrollment requirements. Providers in these licensure categories need to specifically request that their enrollment include approval to dispense durable medical equipment and supplies.

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).

To obtain more information and/or to enroll in IMPACT, providers are directed to the [IMPACT website](#).

The effective date of the enrollment for the provider will be established upon final approval of the application by the department. Payment will not be made for services rendered prior to the effective date of enrollment. Change in ownership or corporate structure necessitating a new Federal Tax Identification Number terminates the participation of the enrolled provider. **Participation approval is not transferable.** Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

M-201.1.1 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Medicare Certification

Suppliers that furnish items or services to Medicare Part B participants must be in compliance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). MIPPA required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30, 2009.

The department will not accept Medicare/Medicaid combination claims for adjudication if the supplier is not in compliance with these requirements. Additional information regarding accreditation is available on the [DMEPOS Accreditation page on the Centers for Medicare and Medicaid Services' \(CMS\) Web site](#).

M-201.2 Enrollment Approval

Before enrollment is approved, the Office of Inspector General (OIG) will investigate each DME provider's qualifications to become a Medicaid provider. This may include an on-site physical inspection of the office, equipment, record keeping, and other areas.

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 M-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 M-201.4.

M-201.3 Enrollment Denial

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

Within ten 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 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.

M-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 must be corrected and the department notified immediately via IMPACT.

Failure of a provider to properly notify the department of corrections or changes may cause an interruption in participation and payments.

If a provider does not submit a claim to the department for 12 months, the provider number will go into a non-participating status. No Provider Information Sheet is generated to alert the provider that they have gone into a non-participating status. If a claim is submitted after the non-participating status is in effect, the claim will reject with error code P48. Prior to resubmitting the claim for processing, the provider must contact the department's Provider Enrollment Services (PES) to change the non-participating status. PES can be reached by calling 877-782-5565 or by [e-mail](#).

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 payees listed if the payee address is different from the provider address.

M-202 Medical Equipment and Supplies Reimbursement

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided and the materials dispensed. Any payment received from a third-party payer must be reflected as a credit on any claim submitted to the department. No copayments may be charged for equipment or supplies.

Arrangements to furnish more costly products, such as an electric wheelchair instead of a standard wheelchair, with the patient supplementing payment made by the department, are not permissible.

Reimbursement for a custom-fabricated item is limited to those items that are manufactured specifically for a single patient (for example, from a molding process) or which are modified by molding or altering the basic construction of a standard item to conform to a patient's deformity. Measuring and custom-fitting an item to a patient, or custom-assembling an item to fit a patient's needs using stock pieces does not qualify for billing as a custom-fabricated item. Unusual sizes do not qualify an item for reimbursement as a custom item.

M-202.1 Charges

Charges billed to the department must be the provider's usual and customary charge billed to the general public for the same service or item. **Providers may only bill the department after the item has been dispensed.**

Note: No separate additional charge is to be made during the initial set-up and rental period for freight, postage, delivery, installation, set-up, instruction, fitting, adjustments, measurement, demurrage, facility visits or transportation, since these services are considered to be inclusive in a provider's reimbursement allowable for the item or service requested.

Charges for services and items provided to participants enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs) must be billed according to the provider's contractual agreement with those entities. Medicaid covers those items or services during the time that the participant has fee-for-service Medicaid coverage. If the participant transitions to an MCO or MCCN, that contract entity is the source of submission of any prior approval requests and/or reimbursement of the items or service.

M-202.1.1 Charges for Replacement Items

Replacements of previously purchased items are subject to all policies that apply to an original purchase, except as described in Topic M-210.4. Under no circumstances can charges be billed for replacement of an item which is under warranty unless the provider can submit proof that the reason for replacement is not covered under the warranty (for example, if the item was destroyed in a fire).

M-202.1.2 Charges for Repair Services

Per Public Act 098-0104, prior approval is required for all wheelchair and power-operated vehicle repairs when the charges for the repair exceed \$400.00. For any hand-priced item per the DME Fee Schedule, providers must identify and separate the charges for labor and materials. The department does not require that a practitioner's order be included with the prior approval request for the repair. DME providers may not break wheelchair repairs into separate claims for purposes of staying under the \$400.00 threshold.

Items that are under warranty are not covered without prior approval. If the warranty covers a portion of the costs (for example, parts but not labor), the request for prior approval and the itemized breakdown of repair charges must show all the costs and clearly indicate which costs are covered under warranty and which will be billed to the department. See special requirements for wheelchairs under Topic M-215.

M-202.1.3 Charges for Loaner Items

If it is the provider's usual and customary practice to furnish and charge for a loaner item pending the completion of repairs, the loaner item may be provided without prior approval. Charges for the loaner item are to be submitted under the appropriate procedure code for the item furnished with the appropriate purchase/rental code of "5" on paper claims. Reimbursement for loaner items will not exceed the department's established rate for a one-month rental of the same item. Refer to Appendix M-1 for billing instructions.

M-202.2 Claim Preparation and Submittal

For general information on policy and procedures regarding claim submittal, and billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100.

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 M-1 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scannability/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: Vendor/Scanner Liaison

M-202.2.1 Electronic Claim Submittal

Any claims that do not require attachments or accompanying documentation may be billed electronically using the X-12 837 Professional Standard. Refer to [Chapter 300, Handbook for Electronic Processing](#).

Providers may also submit claims directly to the department via the Internet through the MEDI IEC system. Further information regarding [MEDI IEC](#) can be found on the department's website.

Providers billing electronically should take 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 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. Refer to Chapter 100 for further details. Form HFS 194-M-C is included as the last page for each Remittance Advice that reports the disposition of electronic claims.

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.

M-202.2.2 Paper Claim Submittal

Form HFS 2210, Medical Equipment/Supplies Invoice, is to be used to submit charges for services covered primarily by the department. Detailed instructions for its completion and mailing are included in Appendix M-1.

All routine HFS 2210 paper claims are to be submitted in a pre-addressed mailing envelope provided by the department for this purpose, Form 1444, Provider Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing. If envelopes are unavailable, the mailing address for these claims is as follows:

Illinois Department of Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

A non-routine claim is a claim to which any document is attached. Non-routine claims may not be electronically submitted. For a non-routine claim submittal, use Form HFS 2248, Special Handling Envelope. If envelopes are unavailable, the mailing address for these claims is as follows:

Illinois Department of Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

The HFS 3797 Medicare Crossover Invoice is to be used to submit charges for Medicare cost-sharing when services are allowed primarily by Medicare. Detailed instructions for its completion and mailing are included in Appendix M-2.

All routine HFS 3797 paper claims are to be mailed to the department in the pre-addressed mailing envelope, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the department. If envelopes are unavailable, the mailing address for these claims is as follows:

Medicare Crossover Invoice
Illinois Department of Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

[Billing forms and envelopes](#) may be requested from the department's website or by submitting an HFS 1517, as explained in Chapter 100.

M-202.3 Payment

Payment made by the department will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the department. Refer to Chapter 100 for payment procedures utilized by the department and explanations of Remittance Advice detail provided to providers.

M-202.4 Fee Schedule

Fee schedules related to durable medical equipment and medical supplies are posted to the department's website under the [Provider Medicaid Reimbursement page](#). The listings identify the department's quantity limitations on each item; whether the item is covered for residents of Long Term Care facilities; whether it requires prior approval; and if the item is covered by Medicare.

A separate listing is shown for supplies that must be billed through the pharmacy billing system with a National Drug Code (NDC).

M-203 Covered Services

A covered service is a service for which payment can be made by the department. Refer to Chapter 100 for a general list of covered services. The services covered in the program include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment.

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

The following general types of services are covered, subject to the limitations described in this handbook:

Nondurable Medical Supplies - Items that have a limited life expectancy, including, but not limited to, surgical dressings, bandages, disposable syringes, etc. These items are used for an individual's care for life maintenance or to expedite hospital discharge and enable the person to be cared for at home.

Durable Medical Equipment - Items that can withstand repeated use, are primarily designed for medical purposes, generally not useful in the absence of illness, disability, infirmity or impairment, and appropriate for use in the home.

Prostheses and Orthoses - Corrective or supportive devices prescribed to artificially replace a missing portion of the body or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

Respiratory Equipment and Supplies - Respiratory items, including oxygen, necessary as a life saving measure, for prevention of a medical emergency or institutionalization, or to facilitate a discharge to home.

Repair and Modifications – Repair and modification of necessary durable medical equipment, prostheses, orthoses and hearing aids is limited to patient-owned items.

Rental of Medical Equipment - Under certain circumstances, such as when a patient's need is known to be temporary, coverage will be for rental rather than purchase of an item. Certain items will be covered on a rent-to-own basis or a continuous rental basis.

Loaner Item –Coverage will be limited to one month rental while repairs are being completed on patient-owned equipment.

Monaural or binaural hearing aids required to improve or correct a hearing deficit are a covered service through the DME Program. Refer to the [Handbook for Providers of Audiology Services](#) for policies on coverage and prior approval for hearing aids.

Eyeglasses and other devices to correct vision are a covered service through the Optical Program. Refer to the [Handbook for Providers of Optometric Services](#) for policies on coverage and limitations.

Foot and ankle services by a DPM can be located in the [Handbook for Providers of Podiatric Services](#). Orthotics ordered by a podiatrist may require prior approval. Refer to the [Podiatrist Fee Schedule](#). This handbook will describe covered and non-covered services.

For information on covered services, please refer to the [DME Fee Schedule](#). Further information regarding coverage may be obtained by calling the Bureau of Professional and Ancillary Services at 877-782-5565.

M-203.1 Practitioner Orders

A written recommendation (order) or plan of care signed and dated by the patient's practitioner (i.e., M.D., D.O., APN, Physician Assistant) is required for the provision of medical supplies and equipment. Orders from a DPM will only be accepted for prosthetic devices for the foot and ankle.

Either electronic or handwritten dates are acceptable. Orders transmitted by telefax or electronically are acceptable, provided it is clear from the contents that the practitioner personally signed the original order. Multiple page orders must have the patient's name on every page.

The department does not accept a plan of treatment by a home health agency as a valid practitioner order for medical equipment and supplies.

Items 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 item would be covered if it were ordered by a physician.

Items 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 item would be covered if it were ordered by a physician.

A prescription signed by a pharmacist will be accepted for medical equipment and supplies related to the administration of prescribed medications, provided the signing pharmacist received the contents as a verbal order from the practitioner whose name is being used on the prescription. A copy of the prescription must be retained by the pharmacy.

Coverage is limited to those items that are specifically included in the practitioner's written order. Items that are added to the order by the supplying provider will not be covered unless the practitioner signs and dates a supplemental order.

Practitioner orders must include:

- Name of patient
- Name of item
- Quantity limitation
- Duration of need
- Directions for use
- Equipment/supply ordered
- Date
- Signature of practitioner with credentials

Once the quantity specified by the ordering practitioner has been provided or the period of time on the order or the proper approval has elapsed, a new written order must be obtained. A new written order must be obtained no less than every 12 months, even for supplies needed for a chronic condition.

M-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.

The department cannot reimburse providers of medical equipment or supplies, including but not limited to the following:

- Items or services ordered by terminated or barred providers
- Items or services provided for the convenience of patients or their families for which medical necessity is not clearly established
- Items or services inappropriate for the patient's medical condition
- Items or services covered by another agency
- Items or services that require prior approval but for which department approval has not been obtained
- Disposable items, when a permanent equivalent exists
- Prepackaged "kits" when components are available in bulk at lower cost.
- Stock orthopedic shoes, unless used in conjunction with a brace
- Medical equipment and supplies for residents of long term care facilities as provided in Appendix M-6
- Prostheses inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function, or eliminate a functional disability
- Items or services for a patient in a state mental or developmentally disabled facility
- Items or services for inmates in a correctional facility
- Items or services provided as part of a hospital inpatient stay
- Items or services provided as part of a hospital outpatient visit that is billed under the department's Ambulatory Procedures Listing (APL) coverage
- Items or services fabricated, fitted or dispensed without an appropriate license
- Any item or service when a less expensive item or service is available and appropriate to meet the patient's need
- Items or services that duplicate other items or services already approved by the department for the same patient
- Items or services for a patient receiving hospice care, as addressed in Topic M-210.8
- Items or services for a patient enrolled in a Managed Care Organization (MCO) or Managed Care Community Network (MCCN)
- An item supplied prior to the participant's eligibility for assistance.
- Exercise equipment
- External wheelchair lifts and ramps (may be covered by other state agencies)
- Vehicle and vehicle lifts and ramps
- Electronic home response systems (may be covered by other state agencies)
- Equipment used for completion of diagnostic testing, such as oximeters, or heart monitors

Routine medical supplies that are carried by Home Health Agency staff as they travel from home to home and which are available for use with any of their homebound patients are not separately reimbursable by the department. Such supplies are considered included in the rate paid to the Home Health Agency.

Medical items or supplies that are ordered by the practitioner for a Home Health Agency for the continuous care and exclusive use of a single patient are covered items.

M-205 Record Requirements

Revised Effective January 1, 2016

Revised Effective January 1, 2021

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.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Falsification of records may also be cause for a referral to the Office of Inspector General and/or the appropriate law enforcement agency for further action.

For medical equipment and supplies, the basic record must include:

- Current practitioner's order
- An explanation of the medical necessity for the item or service dispensed, if this is not included in the practitioner's order, **or** a clinical diagnosis, if not included in the practitioner's order
- Patient's name, recipient identification number (RIN) and address
- A record of items and quantities dispensed and the date(s) dispensed, and
- Prior approval notification or authorization, if applicable

Refer to Topic M-203.1 for further explanation of what constitutes an acceptable practitioner's order.

Providers who dispense equipment or supplies, such as incontinence supplies, on a monthly basis must confirm orders each month prior to dispensing. The confirmation should document the number of items needed as well as the name of the specific items needed for the subsequent month. Confirmation of the order via a live caller (i.e., patient, family member, or caregiver) is not required. If the provider chooses to use an electronic verification system, it must allow the provider to document in the file the name of the person who confirmed the order, as well as the provider's employee who confirmed the order and the date of the confirmation. Orders not confirmed should not be dispensed. Confirmations must be made no more than 14 calendar days prior to the scheduled shipment day of the equipment or supply items.

Suppliers are required to maintain proof of delivery documentation in their files. Proof of delivery is required in order to verify the participant received the items.

Delivery direct to the participant by the provider must include:

- Participant name
- Delivery address
- Quantity delivered

- Sufficient detail description of the item being delivered (e.g. brand name, serial number, narrative description)
- Date delivered
- Participant signature or responsible person and date of signature

Delivery via Shipping or Delivery Service

Proof of delivery is a copy of the complete record tracking the item from the supplier to the participant; for example, a shipping invoice and the delivery services tracking information. The record must link to the delivery service record by a clear method such as the delivery service's package identification number or supplier's invoice number for the package sent to the participant. The proof of delivery must include:

- Participant's name
- Delivery address
- Delivery service's package identification, supplier invoice, or alternative method that links the supplier's delivery documents with the delivery service's records
- Sufficient detailed description to identify the items being delivered (e.g. brand name, serial number, narrative description)
- Quantity delivered
- Date delivered

In addition, in the case of medical supplies, the provider must be able to document purchases of sufficient quantities of the items to support the volumes dispensed and billed. In the case of durable medical equipment or prostheses, the provider must be able to provide a copy of the original wholesale purchase invoice for the item and records of any customization performed by the provider.

M-210 General Limitations and Considerations on Covered Services

Except as outlined in this handbook, all equipment and supplies may be subject to prior approval by the department. In addition, items that do not normally require prior approval but which are dispensed in quantities above the posted quantity limits may also be subject to prior approval. Refer to [DME Fee Schedule](#) that identifies which items require prior approval and the frequency or quantity limitations for those items that do not normally require prior approval.

For general provisions pertaining to prior approval, see Handbook for Providers of Medical Services, [Chapter 100](#), General Policy and Procedures. For specific procedures to follow to obtain prior approval for medical equipment and supplies see Topic M-211 of this handbook.

Whether subject to prior approval or not, all items must be ordered by a practitioner. For further information, refer to Topic M-203.1. The only exceptions are repairs, temporary rentals, and loaner items to meet the patient's need while an item is being repaired.

All items must be medically necessary and must not exceed health care services received by the general public for similar conditions. Items ordered by a practitioner should not be dispensed until necessity is established. There must be a reasonable expectation that the patient will be able to adjust to and use the item and derive benefits from it, in light of his or her medical condition. If at the time of delivery, the item does not meet the needs of the client, the item should not be dispensed or billed. In instances where more than one type of device or category of supplies is available, the department will reimburse for the least expensive item that will meet the medical need.

M-210.1 Eligibility Verification

Verification of patient eligibility for dates of service is the responsibility of the provider. The provider must verify patient eligibility prior to dispensing supplies and equipment.

Prior approval is based upon medical 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. The date of service is the date of delivery except in the case of custom prosthetic devices.

It is imperative that providers check the HFS electronic eligibility systems regularly to determine beneficiaries' enrollment in a plan prior to dispensing items. Electronic Data Interchange vendors (formerly 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 any care

coordination plan in which the beneficiary is enrolled. Further information can be found at the [HFS Care Coordination website](#).

M-210.2 Medical Supplies

Whether prior approval is required or not, the quantity of medical supplies will be limited to the amount indicated by the ordering practitioner or to a reasonable quantity for a month, whichever is less. (**Exception:** a two-month supply may be dispensed for batteries for hearing aids). In the case of items dispensed monthly, confirmation of the need and the quantity of need must be made prior to delivery. For many items, the department has established maximum allowable quantity limits that may be dispensed within a given time period. Quantities up to these maximums may be dispensed without prior approval, if all other requirements in this handbook have been met. Quantities over the designated maximums require prior approval.

If the attending practitioner has ordered a quantity that exceeds the designated maximums, the supplying provider must document the medical necessity and must attempt to obtain prior approval for the entire order. It is not permissible for the supplying provider to dispense only the department's maximum allowable quantity, or to dispense the full quantity and bill the patient for the items in excess of the department's maximum allowable quantity, unless:

- The ordering practitioner confirms that the excess quantity is not medically necessary or
- The department denies the request for prior approval because the excess quantity is not medically necessary or
- The item is being dispensed for patient convenience

Only in instances where the supplying provider can clearly document that items are being dispensed solely for patient convenience can the patient be charged. In such instances, the provider must inform the patient of his or her financial liability before dispensing the items.

M-210.3 Requests for Repair

Charges for repairs of items covered under warranty should be submitted to the manufacturer.

Repairs do not include modifications, technological improvements, or upgrades. A guarantee of at least 180 days on the repair work must be provided.

Repeated requests for repair due to breakage may indicate abuse or neglect and may be reported to or investigated by the department. Verification of abuse or neglect of the equipment could result in denial of coverage for repairs.

M-210.4 Requests for Replacement

Replacements of covered equipment and prosthetic and orthotic items are subject to all policies that apply to an original purchase of the same item. Items should be ordered only when a participant is in need and should not be routinely replaced. Life expectancy of medical equipment is four to five years. In addition, a replacement covered under warranty will not be reimbursed by the department. Equipment that is in working order should not be replaced although it may have exceeded its life expectancy.

If the equipment being replaced requires prior approval and if the item was purchased by the department for the same patient within the past 12 months, the documentation of medical necessity for the first purchase will be deemed adequate for the replacement purchase. The request for prior approval will, however, need to include an explanation of the need for a replacement, enough clinical documentation to support medical necessity, and have a valid practitioner order and signature.

If replacement of an item is due to theft, vandalism, or fire, a police or fire department report is needed.

M-210.5 Equipment Rental Limitations

Total cumulative rental costs must not exceed the usual retail price of the medical equipment. When total cumulative rental costs meet the department's maximum allowable purchase price, the department considers the equipment paid for in full and the property of the patient. Rental costs begin accumulating from the date of delivery. Timely prior approval is required to receive cumulative reimbursement equaling purchase allowable.

The department will normally only rent equipment for ten (10) months. Once the patient has had the piece of equipment in the home for ten months, it is considered purchased and patient-owned. Exceptions are indicated on the DME Fee Schedule.

Certain durable medical equipment is covered on a rental basis only. When there is no longer a medical necessity for a rental, the provider should notify the department of the pickup date of the equipment in order for the prior approval to be ended. A copy of the HFS 3076 prior approval notification with the date the item was picked up should be faxed to the review line at 217-558-4359.

Certain rentals are considered to include all accessories and supplies needed to use the equipment, and these items must not be billed. **Refer to Appendix M-8 for a listing of the accessories and supplies to be included with the associated rental item.** Repairs to rented equipment are the responsibility of the provider.

M-210.6 Long Term Care Residents Service Limitations

Long term care (LTC) facilities have an HFS reimbursement process in place to cover routine medical or personal care supplies, and standard medical equipment to assist with transfer and mobility needs. The LTC facilities submit for these charges on their annual expenditure reports. From those cost reports, a facility's per diem rate is established.

Prior approval will be considered for items that are not routine and would not be considered the LTC facility's responsibility. Refer to Appendix M-6 for a listing of supplies and equipment that will not normally be covered outside of the LTC per diem rate for residents of LTC facilities.

The DME Fee Schedule identifies supplies and equipment that are considered to be included in the LTC per diem reimbursement and cannot be billed to the department.

In most cases, using a ROHO or JAY seating and backing cushions allows standard mobility devices to meet the needs of LTC residents. Standard wheelchairs are inclusive in the LTC per diem rate. The most cost-effective item to meet the medical necessity of participants should be considered at all times.

Medical equipment dispensed prior to the date of discharge from the long term care facility is not billable to the department. If an item is dispensed on the day of discharge from a long term care facility, the DME provider must submit a paper claim in Form 2248, NIPS Special Invoice Handling Envelope provided by the department, and attach an HFS 1624 to request a long term care override for the claim.

For individuals with developmental disabilities residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/MR), the Individual Program Plan (IPP) must support any request for non-routine items or supplies.

These LTC limitations do not apply to residents of Supportive Living (SLF) facilities. A SLF resident is considered to be residing in his or her own home for purposes of determining coverage for medical equipment and supplies.

M-210.7 Hospital Inpatient and Outpatient Service Limitations

Prior approval will not be given or separate payment made for items dispensed during hospital inpatient stays or hospital outpatient visits.

Medical supplies and equipment, braces and prosthetic devices for use by a participant during hospitalization or dispensed in the hospital for continued use after hospital discharge must be included on the hospital inpatient claim and cannot be separately billed fee-for-service by a DME provider.

Following hospital discharge, when a patient requires a brace or prosthetic device that must be adapted for his specific needs, the brace or prosthetic is subject to prior approval requirements. The provider may choose to use either the date the item is fabricated or the date the item is dispensed as the date of service.

Medical supplies and equipment or braces and prosthetic devices supplied during an APL-billable hospital outpatient visit must also be included on the hospital outpatient claim.

M-210.8 Hospice Service Limitations

Hospice is an alternative to traditional care for the terminally ill which emphasizes the reduction of pain and other symptoms of mental or physical distress and meeting the special needs of the terminally ill.

Effective with dates of service on and after July 1, 2012, Public Act 097-0689, known as the Save Medicaid Access and Resources Together (SMART) Act, mandated the department to establish utilization controls to prohibit other care services when an individual is in hospice.

Per 89 Ill. Admin Code Section 140.469(h), for adults 21 years of age and over, medical equipment and supplies are no longer covered for **non-hospice providers** serving adult patients enrolled in the department's hospice program.

Section 2302 of the Affordable Care Act, titled "Concurrent Care for Children," amends sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition of receiving curative treatment upon election of the hospice benefit for a Medicaid or Children's Health Insurance Program (CHIP) eligible child.

Eligible children through age 20 may elect to receive the hospice benefit, but also continue to be eligible to receive covered curative treatment. HFS will reimburse providers for services rendered and items supplied to children through age 20.

M-211 Prior Approval Process

Prior to the provision of certain supplies and equipment, approval must be obtained from the department. Except as noted in this topic, the department's Bureau of Professional and Ancillary Services is designated as the approving authority for medical equipment and supplies requiring prior or post approval consideration.

If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100 for a general discussion of prior approval provisions.

The department will not give prior approval for an item or service if a less expensive item or 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. See Topic M-210.1 for eligibility verification.

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.

Prior approval is used to determine if supplies and equipment are medically necessary and appropriate for the patient's needs and to assure that quantities and charges are within allowable maximums.

Prior approval by the department is required for the provision of all medical equipment or supplies except when the item is:

- Reimbursed by Medicare
- Listed on the department's [DME Fee Schedule](#) with an "N" indicator, denoting that prior approval is not required if the quantity dispensed is within the normal allowable quantity limits established by the department (quantities in excess of the listed maximums do require prior approval).
- Reimbursed by an MCO or MCCN as indicated above in this topic.
- Provided for a resident in a Long Term Care facility, in which case the Long Term Care facility is responsible (see Topic M-210.6 for more details).

Refer to the DME Fee Schedule for a listing of covered items and prior approval requirements.

When the department issues a computer-generated prior approval notification, the HFS 3076, it specifically identifies:

- The patient and Recipient Identification Number (RIN)
- The name of the item or supplies approved, the HCPCS code, and category of service (COS)

- The quantity approved
- The time period for which the items or supplies are approved
- Whether the approval is for purchase, rental, modification, or repair
- The provider name and address
- Prior Approval reference number

Except for quantity dispensed, a claim submitted for payment must match the prior approval exactly or the claim will be rejected. The quantity billed may be either the same as or less than the maximum quantity approved. The date of service must be within the approved prior approval date range. Substitutions may not be made without contacting the department to request a change in the prior approval. Approvals are strictly for that patient for that specific provider.

M-211.1 Prior Approval Requests

Prior approval requests must contain documentation for department staff to make a decision on medical necessity, appropriateness, and the anticipated patient benefits of the supply or equipment requested.

The exact information needed will vary depending on the item requested and the medical condition of the patient, but the process described below is designed to cover the general information that is needed for all requests. Additional topics provide further details on information needed for many commonly requested items. The department's prior approval staff can assist providers in determining the specific information needed to support requests for unusual items or for items not listed. Prior approval requests may be submitted to the department by mail, fax, or in an emergency, by telephone. However, initial requests for wheelchairs requiring HFS 3701H and 3701K forms must be **mailed** to the department.

By Mail:

HFS Prior Approval Unit
P.O. Box 19124
Springfield, Illinois 62794-9124

The supplying provider is to complete [Form HFS 1409, Prior Approval Request](#), when requesting covered items. Instructions for its completion are found in Appendix M-3.

All prior approval request forms must be signed in ink by the supplying provider or his or her designee. Form HFS 1409 must be accompanied by a current signed and dated practitioner order for the items requested. Submitting the practitioner order and any other necessary information to document medical necessity when the initial request is made will prevent delays in processing the request.

By Fax:

Prior approval may be requested by fax. Complete form HFS 1409, following the procedures described above for mailed requests. The completed form, the practitioner order and other documents that substantiate medical necessity can be faxed to 217-524-0099. **Providers should review the documents before faxing to ensure that they will be legible upon receipt.** Colored documents do not fax clearly. The department recommends that such documents be photocopied and the copy be faxed.

The fax number for **initial and renewal prior approval requests** is 217-524-0099.

The fax number for **additional information and change requests** of an existing prior approval is 217-558-4359.

The fax lines are available Monday through Friday, 8:30 AM to 5:00 PM, except holidays.

The department is not responsible for any documentation sent to the incorrect fax line and will not process documentation that is sent to the incorrect fax line.

Emergency Approval Requests:

Emergency telephone approval may be obtained for items or supplies that must be delivered immediately (within 24 hours of request). There are two types of emergency approvals:

- Approvals associated with a hospital or nursing home discharge
- Approvals that are considered “emergency” in nature

For items needed in the home pending the patient’s discharge from a hospital or nursing home, prior approval should be requested by calling the Prior Approval Unit with the request prior to delivering the equipment or supplies.

“Emergency” is defined as a condition or situation that threatens the participant’s life or may cause permanent damage or is needed to relieve immediate pain and suffering. These circumstances are rare, but the item may be provided when there is not enough time to seek approval by telephone. When prior approval is requested for emergency items, providers must also fax proof of this documentation before approval is granted. Providers may request emergency approval by calling 1-877-782-5565, option 5. This number is available Monday through Friday, 8:30 A.M. to 5:00 P.M., except holidays. A caller must be prepared to provide all the information requested on the HFS 1409. The provider is responsible for having a valid practitioner order and statement of medical necessity at the time of the request. When medical supplies or rental of equipment are approved on an emergency basis, coverage will be for a maximum of one month. If the item or supplies are needed for longer than one month, continuing approval must be requested via fax or mail, and must be documented as described in Topic M-211.2.

M-211.2 Documentation Required

The practitioner order must indicate the specifications for the piece of equipment and supplies. **The order must be unique to the patient.** A generic or template version of an order will not be accepted. Refer to Topic M-203.1 for more information on practitioner orders. It is the responsibility of the vendor to have practitioner orders on file for items dispensed.

Certain items require additional specific documentation of medical need, appropriateness, and ability of the patient to benefit from the item. This information must be provided at the time the request is made. Department reviewers may also request additional clarification, either from the supplying provider or from the ordering practitioner. For specific documentation for an item, please reference the appropriate subtopic in this handbook.

M-211.3 Approval of Item or Service

If the item or service requested is approved, the supplying provider and the patient will receive a computer-generated letter, form HFS 3076, Prior Approval Notification, listing the approved items or services. Upon receipt of the Prior Approval Notification and delivery of the equipment/supplies, the provider may bill.

Prior approvals for a medical equipment item or prosthesis are valid for a designated timeframe that is listed on the notification letter. If the item is not deliverable within that period, the supplying provider can request an extension, provided there is documentation to justify ongoing medical necessity. Additional updated or current documentation may be needed in order to justify the continued need of an item that was reviewed. Depending on the time frame of the initial prior approval date span and the date of anticipated delivery, a new request may be required.

M-211.4 Denial of Item or Service

If the item requested is denied, a computer-generated Form HFS 3076C, Notice of Decision on Request for Medical Service/Equipment, citing the denial reason, will be sent to the patient and the supplying provider. **The provider cannot file an appeal of the denial; only the patient may file an appeal.** 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.

M-211.5 Change in Prior Approval Status

DME approvals are not transferable. They are specific to a recipient identification number and to a specific provider number/National Provider Identifier (NPI).

The provider is responsible for ensuring that the HFS 3076 reflects the appropriate information. If approval has been obtained, but corrections are needed on the approval dates, approved quantity, or purchase/rent codes, the provider must submit a review request within 180 days of the approval notification. Prior approvals will not be changed after 180 days. This review can be faxed to the prior approval unit at 217-558-4359. The provider may note the corrections on the approval notice (HFS 3076). The department will send a revised approval notification when the update has been completed. The provider's timely filing date will be from the date of the update to the client's prior approval. If a provider needs to cancel a prior approval request, these can also be directed to the review fax line at 217-558-4359.

M-211.5.1 Transfer From One Supplier to Another

Patients are entitled to a choice of providers and may choose to change providers for rental items or ongoing supply needs. The department may request verification that the patient chose to make the change. If an item is a rent to purchase item and the device has been dispensed, the prior approval will not be changed unless the device is not repairable, is destroyed or stolen, or no longer meets the individual's medical needs.

HFS requires a cancellation statement from the former provider. HFS will end the prior approval and the new provider can then submit a prior approval request under its name and provider number/NPI with the medical justification. Each provider must have their delivery and pick up slips on file.

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

M-211.5.2 Recipient Identification Number Change

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

M-211.5.3 Buy-Out/Change in Ownership Procedures

When a company buys out another company's interest in equipment and supplies 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 equipment and supplies with its 10-digit NPI.

The company that was sold cannot bill or be reimbursed for any dates of service after the end date of enrollment. The new company cannot bill for equipment or supplies with the purchased company's NPI; therefore, all the prior approvals with the purchased company's NPI and Provider Number that extend beyond the company's end date must be changed.

New companies must request new prior approvals for all newly acquired accounts that would require prior approval based on the HFS Fee Schedule within 30 days of the buy-out, by mailing HFS a packet that contains all information below in order for HFS 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:
 - Detailed information describing when the buy-out occurred and the name of the company that was bought.
 - The old provider name, NPI, and provider number and the effective end date;
 - The new provider name, NPI, and provider number and the effective enrollment date.
2. Copies of the purchased company's original Prior Approval Notification Letter, HFS 3076:
 - 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](#), for each prior approval with the new company's information and the balance of the quantity not dispensed. 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 equipment or supplies 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.
 - Any changes that are not submitted in the initial packet will not be processed.
 - Practitioner orders and medical justification do not need to be included for review for the same approved timeframe.

The packet can be mailed to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Buy-Out
P.O. Box 19115
Springfield, IL 62794-9115

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

M-211.6 Timelines

The department is obligated to make a decision on prior approval requests within specified time frames, as identified in 89 Illinois Administrative Code Section 140 Table E. If the department fails to make a decision within the specified time frame, the item is automatically approved, but for a minimum time period. Reimbursement will be made at the provider's charge or the department's maximum rate, whichever is less.

During the department's review of a prior approval request, if the request is incomplete or requires further information to be properly considered, the department may request additional information from either the supplying provider or the practitioner who ordered the service. If additional information is requested, the applicable time period stops. When the required information is received, a new time period begins.

M-211.7 Post Approvals

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

- Determination of the patient's eligibility for 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 90 days following the department's Notice of Decision approving the patient's application.
- Urgently needed equipment or supplies were provided due to a medical need that arose unexpectedly outside the department's normal business hours, so prior approval could not be requested from the department. In such a case, to receive an expedited decision, the post approval request must be received on the first business day after delivery of the items.
- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. 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 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 assistance. In such a case, the post approval request must be received no later than six 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.
- The department may request previous Explanations of Benefits when it is noted that the participant has been enrolled in a TPL, MCO, or MCCN and is transitioning into the Medical Assistance Program.

To be eligible for post approval consideration, all the normal requirements for prior approval of the item must be met and the department must receive the post approval requests no later than 90 days from the date services or items are provided or within the time frames identified above.

This post approval does not include “emergency” prior approval that must be sought in that life-threatening circumstance.

Providers have 180 days from the date of the post approval to bill the department. If necessary, the department will override the timely filing limit.

M-211.8 Bogard Class Members

Pursuant to a court-ordered consent decree entered in 1993 in the class action case *Bogard v DPA, et al*, 88 C 2414, all eligible participants who are members of the court-approved class are assigned Individual Service Coordinators (ISCs). These ISCs are responsible for planning and coordinating all care for the Bogard class members, including obtaining necessary medical equipment and supplies. Bogard class members are persons over age 18 with developmental disabilities who resided in an ICF or SNF as a Medicaid client for a period of more than 120 days, in the aggregate, between March 23, 1986 through April 1, 1994.

When a Bogard class member has a medical need for equipment or supplies, the ISC contacts a DME provider to arrange delivery of the needed items. If the items require prior approval, the ISC will work with the DME provider to complete a [Form HFS 1409](#). The ISC is responsible for submitting the prior approval request to the department. If the department receives a request for medical equipment/supplies from the DME supplier and not the ISC, the request will be returned.

All other policies and procedures contained in this handbook are applicable for services or items provided to Bogard class members.

M-212 Limitations and Considerations on Specific Items

Certain commonly requested or highly specialized items require specific medical information for approval, as described in the following topics. The department has developed numerous questionnaires that will assist providers in determining what information needs to be forwarded to the department. This information is in addition to the basic information included on [Form HFS 1409](#), Prior Approval Request and must clearly document the clinical information that supports medical necessity. Limitations on the department's coverage and related items that are considered included in the purchase or rental price of certain items are also described below.

In some instances, the department has developed a form to guide providers to supply the needed information. In other instances, the narrative below simply describes the factors to be considered and the provider may determine the format for supplying the needed information to justify the request. In all cases, providers should refer to Topic M-211 for general guidance on requesting prior approval.

If an unusual situation exists where the medical circumstances do not fit the general models described below, but the prescribing practitioner thinks that the item is medically necessary, a letter detailing the justification should be submitted with the prior approval request.

M-213 Limitations and Considerations for Medical Supply Items

HFS has quantity limits established on a majority of the supply procedure codes. If a patient requires supplies that exceed the quantity limit in the allotted timeframes, prior approval is required. In addition to the [HFS 1409](#), a letter of medical necessity from the practitioner must be submitted documenting the need for these additional supplies and the estimated duration of need.

If the assigned HCPCS procedure code includes several items, providers can only request/bill for the all-inclusive kit code. Providers cannot bill for each component in the kit separately. When using an NEC code, manufacturer product and pricing information must be submitted with the request for prior approval.

M-213.1 Enteral Nutrition

Providers must complete [Form HFS 3701N, Questionnaire for Enteral Nutrition](#), along with the [HFS 1409 Prior Approval Request form](#), for all requests for enteral nutrition products. Enteral therapy quantities should be requested in units.

All requests for oral supplements must contain the practitioner's clinical documentation that supports the patient's physiological inability to benefit from traditional dietary modifications. Without documentation of medical necessity for oral supplements, these are considered an item of convenience and cannot be covered. Enteral supplies can be billed separately.

If the participant is WIC eligible, in order for HFS to consider an enteral product, the HFS 1409 Prior Approval Request must be accompanied by a WIC denial letter.

M-213.2 Oral Electrolyte Solutions

Oral electrolyte solutions are covered through the Pharmacy Program.

M-213.3 Food Thickeners

Providers must complete [Form HFS 3701M, Questionnaire for Food Thickeners](#), along with the [HFS 1409 Prior Approval Request form](#), for all requests for food thickener products.

Approval is based on the most cost effective means of delivery and the amount that the patient can reasonably consume.

M-213.4 Medical Foods

New Section Added April 2021

Effective November 25, 2020

A request for medical foods for participants through age 20 diagnosed with phenylketonuria, maple syrup urine disease, or homocystinuria requires submission

of the [HFS 1313](#), Medical Food Nutrition Review Questionnaire, along with the [HFS 1409](#) Prior Approval Request form. With the initial request for medical foods, laboratory test results must be submitted confirming the diagnosis, thereby substantiating the need to restrict one or more dietary amino acids. Documentation must be provided that the participant is unable to achieve target levels of the relevant amino acid(s) with other treatments including dietary manipulation and restriction resulting in inadequate nutritional intake and the need for medical foods. Other supporting clinical documentation besides the lab test results must be submitted as applicable and identified on the HFS 1313, including detailed dietary plans, growth charts for the pediatric population, and height and weight for adults age 18 through 20. Ongoing approval requests must include supporting clinical documentation and longitudinal laboratory test reports of appropriately monitored amino acid levels.

The Department will not cover food with minimal nutritional value including but not limited to cakes, cake mixes, candy, candy covered items, chips, chocolate, chocolate covered items, cookies, cookie dough or mix, dessert items, gum, onion rings, pies, foods fortified with caffeine, alcohol (unless preservative in nature), foods containing cannabis, or CBD.

If approval is given, the Department will assign a monthly dollar amount based on the needs of the child to order foods from a supplier. The provider must bill “1” (unit) on the claim to the Department, representing one invoice for the total invoice amount. The provider must submit an invoice to the Department to ensure the items they are providing are compliant with the patient’s nutrition log and the allowable items. Medical foods invoices must be submitted to:

Illinois Department of Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Invoices may also be submitted via fax at 217-524-0099.

M-214 Limitations and Considerations for Medical Equipment

M-214.1 Infusion Pumps and Supplies

HFS covers ambulatory infusion, stationary infusion, and enteral nutrition infusion pumps. These pumps will be reviewed for daily rental based on the practitioner's IV infusion order. Infusion pumps used for long term continuous infusion will be considered purchased and client-owned after 10 months of rental.

The DME program covers the infusion supplies and the pharmacy program covers the drugs being infused. The HFS pharmacy program covers TPN (total parenteral nutrition) solutions.

HFS covers the following line maintenance types:

- peripheral line maintenance billed every 3 days without prior approval,
- peripheral inserted central catheter (PICC, Landmark) billed every week (7 days) without prior approval,
- central line maintenance billed every week (7 days) without prior approval.

HFS covers the following administration supplies:

- metered delivery system (for example, Dial-a-Flow) approved daily requires prior approval,
- gravity delivery billed daily does not need prior approval
- TPN delivery via volume metric pump billed daily does not require prior approval
- CADD type pump (any ambulatory pump that requires medication cassette change) billed per cassette daily does not require prior approval.

See the fee schedule for quantity and time limitations as well as prior approval indicators.

All supplies needed to maintain IV access are included in these codes such as: alcohol pads, betadine swabs, sharp containers, sterile gloves, dressing change kits, flushing syringes, vial adapters, extension sets, IV start kit, tape, IV cannulas (peripheral line), needleless system supplies, needles, cassette with tubing, TPN bag, administration set with filter, metered delivery tubing, etc. and cannot be billed separately. The maximum allowable rate for each code is a flat rate regardless of number of medications or amount of supplies needed. HFS allows the following supplies to be billed separately:

- a thermometer;
- one box of 100 non-sterile gloves per month;
- non-coring Huber-like needles.

Prior approval requests ([HFS 1409](#)) for intravenous therapy supplies and equipment must be complete and specific including the following information:

- All medications to be given, listed by name and not category.

- Practitioner order must include medication, dose, frequency of administration, route of administration and duration of therapy, including a start and stop date. “Indefinite” will not be accepted. Type of IV access should be documented.
- If supplies are requested for line maintenance only, it is important to document what drugs were infused previously and when or why they may be resumed. For example, the line may be kept open as a precautionary measure, for periodic chemotherapy treatments, blood draws, etc.

Equipment and supplies used/requested should correlate with the route and the medications/TPN to be infused. For example, sterile gloves are not routinely needed for IV administration; CVP dressing kits contain one pair of sterile gloves.

Two infusion pumps are rarely medically necessary. One pump can be used for multiple medications by adequate flushing of the IV tubing, staggering medication times or changing tubing.

M-214.1.1 External Insulin Infusion Pumps and Supplies

A prior approval request for an initial external insulin infusion pump must include completion and submission of [Form HFS 1409 Prior Approval Request](#) and [Form HFS 2305F, Certificate of Medical Necessity for External Insulin Infusion Pump](#). Following the initial rental period of three months, prior approval requests for continued rental must include a completed [Form HFS 2305D, Certificate of Medical Necessity for Continuation of External Insulin Infusion Pump](#).

Requests for lancets and blood glucose test strips are covered under the department’s Pharmacy Program. Supplies for use with external insulin infusion pumps including infusion sets, 3cc sterile syringe with needle, and sterile syringe type cartridge do not require prior approval as delineated in the Durable Medical Equipment fee schedule, provided quantity limits over time are not exceeded. If those limits are exceeded, a prior approval request HFS 1409 must be submitted along with an explanation to justify the medical necessity for the amount requested.

M-214.2 Speech Generating Devices

Speech generating devices (SGDs) supplement existing speech or replace speech that is not functional for those participants with severe communication disorders. SGDs may also require peripherals necessary for physical and/or sensory access such as special input/output devices and/or mounting equipment. All SGDs and supplies require prior approval.

The determination of medical necessity for an SGD will be based on the participant’s ability to communicate with multiple individuals in multiple settings while conveying varying message types in a manner sufficient to determine the participant’s care and treatment needs.

A prior approval request for an SGD must include the [HFS 1409 Prior Approval Request form](#) and, at a minimum, the following four elements:

- A prescription and certification of medical necessity from the participant's practitioner;
- A formal, written evaluation completed by a speech-language pathologist that is completed within six months preceding the date of submission of the prior approval request.
- A descriptive, narrative report of successful trial use of the requested SGD and any necessary components needed for utilization;
- An individual treatment and implementation plan

Appendix M-5, Prior Approval Request Guidelines for Speech Generating Devices , provides a detailed guide for the documentation required for a prior approval request of an SGD. Individual medical circumstances may require additional and/or different documentation. This department reserves the right to request a second opinion and/or additional evaluation(s) to assist with clarifying the medical necessity of the requested/prescribed equipment.

M-214.3 Respiratory Management Items

M-214.3.1 C-PAP or BiPAP Equipment

A prior approval request for an initial one to three-month rental period of C-PAP equipment must support the medical need for the device and the anticipated benefits to be derived from the device. In addition to the [HFS 1409 Prior Approval Request form](#), the supplying provider should obtain and submit the following documentation from the ordering practitioner:

- A sleep study that indicates a life threatening event(s),
- Evidence from a C-PAP titration study documenting alleviation of life-threatening respiratory events, and
- A signed and dated practitioner order for the device, which includes a certification by the practitioner that the patient has shown the desire and ability to fully utilize the C-PAP device.

A prior approval request for initial rental of BiPAP equipment must support the medical need and anticipated benefits of the device, and in addition, must document that these benefits cannot be achieved using C-PAP equipment. In addition to the [HFS 1409 Prior Approval Request form](#), the supplying provider should obtain and submit the following documentation from the ordering practitioner:

- Evidence that the use of the C-PAP equipment by the patient did not alleviate the threat to life as documented by a sleep study while the patient was using C-PAP, or evidence that the patient could not tolerate C-PAP,
- A sleep study that indicates a life threatening event(s),
- Evidence from a titration study documenting alleviation of life-threatening respiratory events, and

- A signed and dated practitioner's order for the device, which includes a certification by the practitioner that the patient has shown the desire and ability to fully utilize the BiPAP device.

Renewals after the trial period will require a new prior approval request including the [HFS 1409 Prior Approval Request](#) form and the practitioner-completed [HFS 3701F C-PAP/BiPAP Renewal Questionnaire](#) and compliance download for 30 days.

If it is documented that a patient did not tolerate the C-PAP/BIPAP during the sleep study, a one-month rental period will be approved. All renewals will require a new [HFS 1409 Prior Approval Request](#) and the practitioner-completed [HFS 3701F C-PAP/BiPAP Renewal Questionnaire](#) and compliance download for 30 days.

C-PAP/BIPAP equipment is considered purchased and patient-owned after ten months of rental. All related supplies and accessories, not limited to the following, are included in the rental period and cannot be billed separately:

- Disconnect alarm and connectors
- Circuits, adapters, connectors and tubing
- Hydroguard filters
- Bacteria filters
- Swivel adapters
- Water traps
- Temperature probes
- Tubing with integrated heating element
- Mask and headgear

M-214.3.2 Oxygen Supplies and Equipment

Oxygen and related supplies and equipment require an [HFS 1409 Prior Approval Request form](#). The patient must be seen and evaluated by the treating practitioner within 30 days prior to the initial certification. The patient must be re-evaluated within 90 days of re-certification. Requirements for documentation for oxygen content and equipment include, but may not be limited to the following:

- Practitioner order that contains the liter flow, frequency, and duration of need
- Measurements of arterial PO₂ or oximeter oxygen saturation that is dated and certified by a practitioner and includes the condition under which the oxygen level was obtained i.e., at rest, room air, during exercise, at rest nocturnal.
- Overnight oximeter when oxygen orders are limited to nocturnal use only.
- If the patient arterial PO₂ is above 55mmHg or O₂ oximeter saturation is above 88% at rest on room air, a statement from the prescribing practitioner providing the clinical documentation for medical necessity will be required.

For patients requiring oxygen at a liter flow rate less than 0.5 liter minute and/or an oxygen frequency ordered as needed, an O₂ concentrator will not be considered. In such cases, a tank delivery system along with oxygen content will be considered.

Oxygen for Long Term Care Residents

Long Term Care (LTC) facilities have the option of 1) billing the department directly for oxygen for their residents or 2) obtaining oxygen from an enrolled DME provider. If an LTC facility elects to bill the department directly for oxygen they must enroll as a DME provider and will be assigned a provider number ending in an “800” series. The facility, enrolled as a DME provider, is not required to obtain prior approval to supply oxygen to its residents. DME providers that supply oxygen to LTC residents must request prior approval.

Concentrators are not to be used unless the resident has an ongoing need for oxygen that requires a minimum of one liter of oxygen per minute continuously or a minimum of eight hours nocturnally. The resident must have no more than an 88 percent oxygen saturation level on room air. No other method of oxygen delivery is reimbursable for a resident during a month in which an oxygen concentrator is reimbursed by the department for that same resident.

When an LTC facility obtains oxygen equipment and supplies from a DME provider, **both** providers must exercise care to ensure that the department is not billed twice for the same service. The LTC facility is responsible for the cost of the first tank of oxygen used by a resident each month. The first tank is defined as:

- One “H” tank (6900 liters) or
- Two “E” tanks (623 liters) or
- 20 pounds of liquid oxygen.

The DME provider may not bill the cost of this first oxygen tank fill for each resident each month to the department. Oxygen fills beyond the initial first fill may be billed to the department by either the DME provider or the LTC facility, but not by both.

M-214.3.3 Apnea Monitors

Prior approval requests for infant home apnea monitors must be accompanied by submission of a completed [HFS 1409 Prior Approval Request form](#) and [HFS 2305G, Questionnaire for Home Apnea Monitor](#). The apnea monitor must be equipped with an event recorder. The ordering practitioner should establish a specific plan for periodic review and length of need before initiating use of the monitor. The information should be on the practitioner order and plan of care.

An apnea monitor is considered purchased and patient-owned after 12 months of rental. **All related supplies and accessories, not limited to the following, are included in the rental period and cannot be billed separately:** belts, Ambu bag, electrodes, leads, and cables. The rental allowance also includes training sessions for caregivers on infant CPR and on use of the monitor, retrieval and interpretation of data from the event recorder, and submission of compliance downloads. Supply items for the apnea monitor may be approved separately, if the apnea monitor is already owned.

A back-up electrical system or alterations to the living quarters to implement use of the apnea monitor is not covered.

A request for additional months of rental following previously approved rental requires submission of compliance downloads, event recordings, pneumograms or other documentation substantiating ongoing medical necessity.

M-214.3.4 Ventilators

Volume/pressure ventilators are approved via the [HFS 1409 Prior Approval Request form](#) for continuous rental only, and include all maintenance and supplies including but not limited to:

- Humidifier and heater
- In-line thermometers and temperature probes
- Battery power cables
- Spirometer valve or stick
- Fuel cells
- Disconnect/low pressure alarm
- Circuits
- Bacteria filters
- Peep valve
- Exhalation valve
- Exhalation diaphragm
- Test lung
- Batteries (internal and external)
- Battery cables
- Trach swivel adapter
- All other filters, including PALL, hydrophobic and hydroguard filters
- Drainage bags/water traps
- CO₂ monitor
- O₂ analyzer
- Respirometer
- Cleaning Supplies (i.e., Cidex, Control III, vinegar).

Supplies included in the rental are not separately billable.

Related items that may be provided and billed separately with proper medical documentation and prior approval are:

- Pulse oximeter
- Suction machine
- Compressor
- Apnea monitor
- Oxygen
- Tracheostomy tube

- Tracheostomy care/clean kits
- Suction catheters
- Ambu bag

A portable volume ventilator as a backup in case of power failure may be approved with medical documentation that the patient requires mechanical ventilation for more than 22 hours per day. Additional supplies or related equipment are not separately billable as these may be transferred from the primary ventilator to the portable ventilator if it is needed.

M-214.3.5 Respiratory Assist Device (RAD)

Rental of a Respiratory Assist Device (RAD) may be approved for patients who are able to breathe on their own but are unable to produce respirations that are strong enough and deep enough to maintain relatively normal PO₂ and PCO₂ levels.

For patients needing ventilator support for 12 hours per day or less (usually during sleep), a RAD may be approved with submission of an [HFS 1409](#) and the following medical documentation of need:

- A history of hospitalizations related to the need for ventilator support,
- An explanation of circumstances or diagnoses leading to the need for a ventilator,
- Arterial blood gas (ABG) levels for two successive nights, each time before putting the ventilator on the patient, and
- ABG for the associated mornings when the ventilator is removed.

All related supplies and accessories, not limited to the following, are included in the rental period and are not separately billable:

- Disconnect alarm and connectors
- Circuits, adapters, connectors and tubing
- Hydroguard filters
- Bacteria filters
- Swivel adapters
- Water traps
- Temperature probes
- Tubing with integrated heating element
- Mask and headgear

Information on BiPAP and CPAP can be found in Topic M-214.3.1.

M-214.3.6 Airway Clearance Devices

Requests for airway clearance devices including percussor – electric or manual, intrapulmonary percussive ventilator (IPV), cough stimulating device – alternate positive/negative pressure (mechanical insufflation-exsufflation device), therapy vest

and hoses (high frequency chest wall oscillation device - HFCWO device) require prior approval and completion of the [HFS 1409 Prior Approval Request](#) form and [Form HFS 2305B, Questionnaire for Airway Clearance Device](#) and submission of the relevant clinical records. Oscillatory positive expiratory pressure device non-electric does not require prior approval if dispensed within the allowable quantities listed on the DME Fee Schedule.

All of the above devices are considered on a 10 month rent to purchase basis (three months for the initial rental) except an HFCWO device is 15 months of rent to purchase with the initial rental period of six months. An oscillatory positive expiratory pressure device non-electric is a purchase item. At the completion of the appropriate rent to purchase period, the equipment is considered purchased and patient owned. During the rent to purchase interval the allowable for the rental is inclusive of patient education on proper use and care of the equipment, routine servicing including repairs and replacement of components to keep the equipment operational, and the equipment itself.

A prior approval request for continued rental of an airway clearance device following the initial rental period requires an [HFS 1409 Prior Approval Request](#) form and updated clinical information to allow assessment of the effectiveness of the equipment, and completion of the [Form HFS 2305C, Questionnaire for Continued Rental of Airway Clearance Device](#). Continued rental of a HFCWO device also requires submission of compliance reports/downloads.

M-214.4 External Defibrillators

Examples of documentation used to evaluate a prior approval request for an external defibrillator can include any of the following:

- Hospital admission history and physical
- Discharge summary for hospital admission
- Cardiology consultations including those from electrophysiologist and cardiovascular surgeon
- Cardiac diagnostic testing:
 - Echocardiogram (transthoracic and/or transesophageal)
 - Cardiac magnetic resonance imaging (MRI)
 - Cardiac computed tomography (CT)
 - Radionuclide angiography
 - Gated myocardial perfusion single-photon emission computed tomography (SPECT)
 - Gated myocardial perfusion positron emission tomography (PET)
 - Cardiac catheterization report – diagnostic and interventional for angioplasty and stent insertion
- Operative reports for coronary artery bypass grafting (CABG) and explanation of automatic implantable cardioverter defibrillator (AICD)
- ECG and Holter monitor reports where a conduction disturbance is alleged
- Outpatient longitudinal cardiology progress notes especially the most recent

All of these will not be present in every case, but those reports that are relevant must be submitted, along with the [HFS 1409 Prior Approval Request](#) form.

[Form HFS 2305L, Informed Consent for Future LifeVest Rental Related to Compliance with Cumulative Wear Time](#), must be read, signed, and dated by the patient at the time an automatic external defibrillator with integrated ECG analysis garment type is dispensed to the patient. This form must be submitted with the original prior approval request for the initial rental. Each prior approval request for ongoing rental of an external automatic defibrillator with integrated ECG analysis garment type following the previously approved rental period must include downloads reflecting compliance over the entire most recently approved rental period. If those graphics are not provided, an explanation must be submitted. Any time period for which a download is not submitted will be counted as zero wear time calculating the cumulative wear time over the entire rental period being considered. A cumulative wear time of 90% or more over the entire most recently approved rental period is a contingency to consider any request for ongoing rental of an automatic external defibrillator with integrated ECG analysis garment type. If the compliance is less than 90%, the request will not be further considered.

Updated clinical information must be submitted with prior approval requests for continued rental to substantiate ongoing medical necessity.

M-214.5 Items with Compliance Download Capability

If the equipment has the capability to download usage information, the provider must submit it with each prior approval request to monitor compliance. These types of equipment include but are not limited to C-PAP, BiPAP, apnea monitor, and external defibrillator vest garment type and high frequency chest wall oscillation devices (therapy vest).

M-215 Limitations and Considerations for Mobility Devices - Manual and Power Wheelchairs/Scooters

A mobility device will only be considered for coverage if the patient's condition is such that without it, he or she would be confined to a bed or chair and unable to accomplish mobility related activities of daily living. Approval decisions are based on the equipment that is the least costly alternative that adequately meets the patient's mobility needs. Approval will not be granted for equipment with the sole purpose of allowing the patient to engage in leisure, recreational, or social activities, or if meeting the demands of these activities results in a proposal that is more costly than a mobility device that sufficiently meets the patient's mobility needs. The department will maintain only one chair.

Prior approval requests for a new mobility device, or modifications and customization of an existing one must include a completed [HFS 1409 Prior Approval Request](#) form, and a signed and dated practitioner order that includes the diagnoses and documentation substantiating medical necessity. Prior approval for a mobility device repair is required when charges exceed \$400.00, and no practitioner order is needed. For prior approval requests for new mobility devices, the practitioner should also complete the [Power Mobility Devices and Custom Manual Wheelchairs Physician's Form HFS 3701K](#). When a new mobility device is being proposed, the mobility device therapist and primary therapist must submit, sign, and date the [Seating/Mobility Evaluation HFS 3701H](#), noting their area of expertise such as certified rehabilitation technician specialist (CRTS), registered rehab technical specialist (RRTS), or assistive technology practitioner (ATP). The patient or caregiver, in the event the patient cannot perform the task, must sign and date this form as well. It is imperative that all sections of these forms are completely filled out including rationalization and medical justification for all components in the proposal. All evaluations must be completed no later than 120 days prior to submission of the request. Additional instructions on how to complete and submit the above documents are in the [Required Documentation for Power Mobility Devices and Custom Manual Wheelchair Requests](#) on the department's website.

A detailed itemization of components and HCPCS for a new mobility device, repairs, modifications, or customization of an existing one must be provided along with catalog pricing reflecting manufacturer's suggested retail pricing and dealer actual acquisition cost that includes all discounts.

Labor will be considered for repairs/modifications on an existing mobility device. A separate labor charge for fabrication of a new mobility device will not be allowed. Payment for a new device includes all fitting or measuring of the patient, assembly, delivery, set-up, and patient or caregiver education on care and operation of the wheelchair. Shipping fees and taxes are not billable. Repairs of medical equipment owned by the participant and is out of warranty will only be considered for payment if the repair parts and labor do not exceed 75 percent of the cost of a new unit.

Billing may be submitted only after the mobility device is delivered to the patient. The mobility device is expected to meet the patient's mobility needs at the time of delivery. If the needs of the patient are not met, the item should not be delivered or billed. The provider must maintain in their records a copy of the delivery slip for a period not less than three years from the date of delivery as confirmation of the delivery. The delivery slip must include the brand name, model, and serial number of the mobility device that has been signed and dated by the patient or legal guardian acting on behalf of the patient who has received the equipment.

Mobility devices are expected to have a life expectancy of five years. Equipment that is in working order should not be replaced although it may have exceeded its life expectancy. Replacements should be ordered when a participant is in need of an item and should not be routinely replaced. Repeated requests for repair due to breakage may indicate abuse or neglect. Equipment abuse may be reported to and investigated by the department. Verification of abuse or neglect of the equipment could result in denial of coverage for repairs.

Circumstances that may justify an earlier replacement include but are not limited to the following:

- The wheelchair has been stolen. An official police report must be submitted with the replacement request. The request for replacement must also include a statement that the theft is not covered by auto or homeowner's insurance.
- The wheelchair has been damaged or destroyed in a motor vehicle accident, by an act of nature, or by vandalism. An official police report must be submitted with the replacement request. The request for replacement must also include a statement that the damage is not covered by auto or homeowner's insurance and the mobility device is out of warranty.
- The wheelchair has been damaged beyond repair in some other manner that is not covered by auto or homeowner's insurance and the mobility device is out of warranty. The equipment must not be thrown away prior to the department's decision on replacement.
- The patient's condition has changed in a way that makes the existing mobility device inadequate to meet the patient's current medical needs. Examples might include dramatic changes in the patient's weight, a growth spurt of a child, or deterioration of the patient's medical condition. Documentation of these changes and medical justification must accompany the request for replacement.

All policies and prior approval requirements that applied to the purchase of the original mobility device also apply to a replacement mobility device.

The following must be submitted with a prior approval request for a new wheelchair or power-operated vehicle (POV):

- [HFS 1409](#) (Prior Approval Request Form)
- [HFS 3701K](#) (Power Mobility Devices and Custom Manual Wheelchairs Physician's Form)
- [HFS 3701H](#) (Seating/Mobility Evaluation Form)
- Itemized price breakdown of all needed components, accessories, and modifications and HCPCS codes
- Itemized price list on the DME supplier letterhead that includes the dimensions of the proposed seating, quantity for each item, HCPCS code, item description, manufacturer's suggested retail pricing (MSRP, verified by submitted catalog pricing), and dealer acquisition cost including all discounts. Dealer's acquisition cost must be verified by submitting manufacturer's cost statement. Quotes are not acceptable substitutes for MSRP.
- A signed intent to deliver statement from the DME provider.

If a request for a custom manual wheelchair and power mobility device is received without these completed forms, the request will be returned as invalid and must be resubmitted in its entirety with a new prior approval request form. These requests will be accepted via mail only.

If a client residing in a long term care facility (LTCF) requires a wheelchair, it is the responsibility of the LTCF to provide any non-custom manual or power mobility devices. HFS will consider/review custom manual or power mobility devices unless it is determined that Medicare or a private insurer is responsible.

M-215.1 Standard Manual Wheelchairs (MWC)

Requests for a standard MWC must adhere to general guidance in section M-210, M-211, and M-215. These wheelchairs can either be purchased or rented. A completed [HFS 1409 Prior Approval Request](#) form and a practitioner-completed [HFS 3701L Standard Manual Wheelchair Questionnaire](#) must be submitted.

M-215.2 Power Mobility Devices and Custom Manual Wheelchairs

Power mobility devices and custom manual wheelchairs are priced by each HCPCS code listed on the itemized pricing sheet. Providers will be notified via the Prior Approval Notification Letter (HFS 3076) and will also receive a copy of the pricing breakdown, if approved. The maximum allowable rate established for each item or service shall be the rate on the department's fee schedule. If there is no rate established on the department's fee schedule, the maximum allowable rate established for each item in a mobility device proposal will be the least amount obtained using three different methods:

1. Medicare rate minus 6%, as identified in the [DME Fee Schedule](#). This is Medicare pricing minus 6% by HCPCS code.
2. MSRP (manufacturer's suggested retail pricing). This is verified by submitted catalog pricing. Quotes are not acceptable substitutes for MSRP.

3. Dealer acquisition cost multiplied by 1.5. Dealer acquisition cost is the cost of the item minus all manufacturers' discounts to the dealer. This is verified by the submitted manufacturer's cost statement.

M-215.3 Rental

All MWC rentals require prior approval. Wheelchair rentals are normally approved if the patient's need is temporary and recuperative. An [HFS 1409 Prior Approval Request form](#) and a practitioner-completed [HFS 3701L](#) is required for review for a MWC rental. If the patient's need is temporary and recuperative, the HFS 3701L questionnaire should document the medical need by supplying the same basic information as described for a purchase. In addition, the questionnaire should specify the length of time the wheelchair is expected to be needed. Generally, these rentals are for one month, for use during the recuperation of an acute need and can be extended depending on the medical need. If continuous rental is for a 10-month duration, the wheelchair will be considered purchased and patient-owned.

During the rental period, any component, cushion, and accessory is included in the monthly rental reimbursement except a semi-reclining or full-reclining back. Rental coverage of a semi-reclining or full reclining back requires specific documentation of medical need, including the practitioner's order.

Approval for medically essential components provided at the time of the initial rental will not be considered for reimbursement until the wheelchair reaches purchase price. Once purchased, the provider may submit a prior approval request for any medically essential components that were provided with the initial rental wheelchair. The request must contain the practitioner's order along with specific medical documentation for the components provided. This request must be received by the department within 30 days of the date that the rental wheelchair is converted to purchase.

Billing for the retroactively approved components will require a time override by the billing department.

If a rental wheelchair is converted to purchase, the inclusion of any non-standard accessories in the purchase price is subject to specific documentation of medical need including a practitioner order. Basic cushions are considered included in the rental. MSRP supported by catalog pricing and dealer cost must be submitted for consideration of payment for any non-standard accessories.

M-215.4 Repairs

A repair is replacing a like part with a like part to restore equipment to its original condition. (i.e., replacing a worn-out tire with a new tire). Prior approval is required for repairs when charges exceed \$400.00. Providers may not break wheelchair repairs into separate claims for purposes of staying on the \$400.00 threshold.

In a situation where a participant has two mobility devices and the need arises for repairs, the department will maintain only one of the mobility devices. If repairs are needed for an existing mobility device that is participant-owned, the brand make, model, serial number, and date of purchase, if known, of the device receiving the repairs must be provided. If the required information is not provided, the prior approval request will be sent back as invalid.

Prior approval requests ([HFS 1409](#)) for repairs to an existing mobility device must include the diagnoses and an itemized breakdown of the repairs being performed. MSRP and dealer acquisition cost must accompany these requests.

If a provider sends in a request for repairs, and sends another request that creates an overlap, the prior approval request will be returned to the provider to send in one request for repairs.

If the patient resides in a LTCF, including an intermediate care facility for individuals with intellectual disabilities (ICF-IID), the cost of the repairs will be covered by the department only if the patient owns the wheelchair and is further qualified by the information in the next paragraph.

If the patient resides in an ICF-IID, the department shares responsibility for payment for wheelchair repairs with the Department of Human Services (DHS). In general, if a non-custom wheelchair was purchased by DHS, DHS will be responsible for the cost of the repair. Repairs to a custom wheelchair or a patient owned wheelchair that was not purchased by DHS will generally be paid by the department. However, all requests for prior approval on repairs, and modification, regardless of the amount of billed charges, must be sent to the department. If department staff determines that DHS is the responsible party for reimbursement, the department will refer those claims to DHS and will advise the provider that this has occurred.

M-215.5 Modifications/Customization

If a component is being added to an existing mobility device that was not originally on it, this is considered a modification. Modifications or customization of a wheelchair are not considered repairs.

In a situation where two mobility devices exist and the need arises for modifications or customization, the department will maintain only one of the mobility devices in an operational state. The brand, make, model, serial number, and date of purchase, if known, of the device receiving the modifications/customization must be provided. If the required information is not provided, the prior approval request will be sent back as invalid.

Prior approval is necessary for all requests for modifications/customization of an existing mobility device and must include a signed and dated practitioner order

including the diagnoses and an itemized breakdown of the modifications/customization being performed. The request for modification or customization must meet the patient's medical need.

If the provider requests modifications to a newly approved mobility device, they will be informed that they need to cancel the newly approved prior approval request and resubmit a new prior approval request that includes all of the requested items.

If the patient resides in a long term care facility, including an ICF-IID, the cost of the modifications/customization will be covered by the department only if the patient owns the wheelchair and is further qualified by the information in the next paragraph.

If the patient resides in an ICF-IID, the department or Department of Human Services (DHS) is responsible for payment of the wheelchair based on whether the item is custom. DHS is responsible for non-custom wheelchairs. HFS is responsible for custom wheelchairs including items initially purchased by DHS and later customized. A patient-owned wheelchair not purchased by DHS will be the responsibility of the department. All requests for prior approval must be sent to the department. If a claim is received that is DHS responsibility, the department will refer those claims to DHS.

Requests for prior approval must include the following:

- [HFS 1409](#) (Prior Approval Request)
- [HFS 3701K](#) (Power Mobility Devices and Custom Manual Wheelchairs Physician's Form)
- [HFS 3701H](#) (Seating/Mobility Evaluation Form)
- Itemized price breakdown of all needed components, accessories, and modifications
- Itemized price list on the DME supplier letterhead that includes the dimensions of the proposed seating, quantity for each item, HCPCS code, item description, manufacturer's suggested retail pricing (MSRP, verified by submitted catalog pricing), and dealer acquisition cost. Dealer's acquisition cost must be verified by submitting manufacturer's cost statement. Quotes are not acceptable substitutes for MSRP.
- A signed intent to deliver statement from the DME provider.

M-215.6 Batteries, Chargers, and Cushions

Batteries, chargers, and cushions require prior approval and are considered purchases.

If a patient owns a power wheelchair, two batteries are allowed per year. Additional batteries require additional documentation to justify the need beyond the two per year maximum limit.

M-216 Limitations and Considerations for Prosthetics/Orthotics

Prosthetic and orthotic devices include corrective or supportive devices prescribed to artificially replace a missing portion of the body; to prevent or correct physical deformity or malfunction; or to support a weak or deformed portion of the body. Requests for prior approval of prostheses and orthoses must include extensive documentation of the functional limitations the device will address and the extent of improvement or functionality that the device is expected to provide. Although the exact details will vary depending on the device requested, a simple statement of the diagnosis is not adequate to support the prior approval request.

In instances where an item is fabricated for the patient, a provider may choose to use either the date the item is fabricated or the date the item is dispensed as the date of service. The department allows this flexibility in date of service to address concerns about continued eligibility in cases where some time may elapse between fabrication and delivery of an item. This choice must be made at the time the item is fabricated and may not be changed subsequently. The device should be dispensed prior to charges being submitted.

M-216.1 Prosthetic Devices

Prior approval requests for prosthetic devices must be accompanied by submission of a completed [Form HFS 2305J, Questionnaire for Prosthesis](#), along with the [HFS 1409 Prior Approval Request](#) form. The practitioner order needs to accompany the request and be specific to the items that are ordered to meet the specific medical need. When requesting a prosthetic, the provider needs to specify if it is for the right side, left side, or bilateral.

When requesting socket replacements for an existent prosthetic, the provider must submit medical justification as to the need (for example, shrinkage).

A permanent prosthetic device requires prior approval. At a minimum, the request for prior approval should contain the following information:

- Medical history, including factors which contributed to the amputation
- Date, type and reason for the amputation
- A description of the stump and its healing status, including any unusual characteristics which will affect the success of the prosthesis
- Functionality expected to be gained with the permanent prosthesis, including potential for self-care or employment

Additional information should be supplied if it supports the request for the prosthesis.

The practitioner order should specify practitioner's degree (MD, DO, DPM, APN, PA). Orders from a DPM will only be accepted for prosthetic devices for the foot and ankle.

If the patient has had a preparatory prosthesis for less than six months, requests for the initial permanent prosthesis should include extensive detail on patient compliance, adjustment and rehabilitation progress with the preparatory prosthesis.

Only one prosthetic device per limb will be approved. A second device to serve as a spare or multiple devices for the same limb (for example, an artificial arm with a hook and one with a hand) will not be approved.

Requests for replacement of existing prostheses must include documentation of why the existing device no longer meets the patient's needs and evidence that it cannot be repaired or modified to meet those needs.

M-216.2 Orthotics

Prior approval requests for orthotics must be accompanied by submission of a completed [Form HFS 2305N, Questionnaire for Orthotics](#), [HFS 1409 Prior Approval Request](#) form and a practitioner order. The practitioner order needs to be detailed as to the items that are ordered to meet the specific medical need. Knee orthotics are considered separately with a distinct questionnaire as noted below.

Providers must submit justification for the orthosis and explain that the orthosis is expected to restore or improve function or structural characteristics of the specified anatomical area in order to facilitate accomplishment of activities of daily living (not sports-related activities).

Any custom-molded or custom-made orthosis must have a statement of medical necessity which documents why the patient's medical need cannot be met with a pre-made or custom-fitted orthotic. This may include but not be limited to a unique physical characteristic that requires use of a custom-made orthotic (i.e., deformity, size of thigh and calf, or minimal muscle mass to suspend). Devices for which the patient is measured and fitted using stock parts are considered custom-fitted, not custom-made. Unless sufficient documentation of medical need for custom-made orthotics is submitted, prior approval will be granted for the least costly, pre-made orthotics.

Stock orthopedic shoes are covered only if a brace must be attached to at least one of the shoes.

- Depth inlay shoes, with or without inserts, are covered only for patients with foot ulcers, demonstrated impaired healing of the foot or toes, or a history of amputation or other serious medical foot problems due to diabetes or venous insufficiency. A simple diagnosis of diabetes is not sufficient medical justification for depth inlay shoes.
- Custom molded shoes should only be requested if there is documentation that stock orthopedic shoes do not meet the patient's needs.

Repairs and modifications to orthotic/prosthetic items require prior approval. Modifications to orthotic items require a practitioner order. In addition to the prior approval request for a repair, the department will need:

- 1) A description of the repair or modification, to include type of orthotic that is being repaired or modified; and whether the item is for right, left, or bilateral part
- 2) An itemized statement listing parts/materials with the acquisition cost of each
- 3) Labor time

A prior approval request for a knee brace must include a completed [HFS 2305M Knee Brace Questionnaire](#) along with the [HFS 1409 Prior Approval Request](#) form.

M-216.3 Cranial Remolding Orthosis and Cranial Cervical Orthosis Congenital Torticollis Type

These orthotic devices are normally approved between ages four to 12 months, as this age range allows the greatest potential for modification of skull shape with an orthotic. They are less effective if instituted after 12 months of age and are not effective after 18 months of age. They can be approved by exception up to 16 months of age, based on medical necessity.

A prior approval request for a custom cranial remolding orthosis or cranial cervical orthosis congenital torticollis type must include submission of the following:

- Signed order
- [HFS 1409, Prior Approval Request](#) form
- [HFS 2305E, Questionnaire for Cranial Remolding Orthosis or Cranial Cervical Orthosis Congenital Torticollis Type](#) or narrative covering the content in the questionnaire
- Orthotic consultative report with skull anthropometric measurements including the head circumference and measurements that allow calculation of the cephalic index, cranial vault asymmetry, cranial base asymmetry, and orbitotragial depth asymmetry and any available diagrams
- Photographs and / or scans of the head should also be submitted, if they are available

If the request for prior approval authorization concerns a second orthosis, please submit the following:

- Reason for the second orthosis
- Updated clinical information and orthotic consultative report with all relevant measurements since institution of the first orthosis for comparative purposes
- Statement that the first orthosis can no longer be modified
- Indication of compliance with wear times.

If the cranial remolding orthosis is being used as part of the post operative treatment plan for craniosynostosis, please submit the operative report and consultative reports from the craniofacial or pediatric neurosurgeon.

M-217 Other Commonly Requested Items

M-217.1 TENS Unit

Requests for a TENS unit must include the [HFS 1409 Prior Approval Request](#) form and specific information including clinical notes and physical therapy evaluation notes concerning the patient's medical condition and need. Approval will be given for no more than a two-month trial period. This two-month trial period will provide time for the ordering practitioner to follow up with the patient and complete the [HFS 3701E, Questionnaire for TENS Unit](#). A new [HFS 1409](#) form, along with the practitioner-completed [HFS 3701E](#) is required for rental beyond the trial period. **All related supplies and accessories are included in the rental period and cannot be billed separately.** After a period of 10 months, the item is considered purchased.

M-217.2 Home Uterine Monitoring

All home pregnancy monitoring devices require prior approval. Prior approval may be obtained by telephone for patients meeting the below listed criteria for each equipment item. All requests are reviewed on an individual basis.

Home Uterine Monitoring

- Must be at least 24 weeks gestation; gestation of less than 24 weeks may require additional information
- Hospitalized for preterm labor at 24-36 weeks
- Cessation of labor accomplished by administration of tocolytics (terbutaline, procordia, etc.)
- Discharged to home on oral or subcutaneous tocolytics
- Multiple gestation pregnancy
- History of preterm labor and delivery
- Cervical status change (lengthening or dilation)
- Cervical effacement
- Contraction threshold
- Gravida/para

Pregnancy-Induced Hypertension Monitor

- Covered for diagnosis of pregnancy-induced hypertension, previous pregnancy induced hypertension or pre-eclampsia
- Hospitalizations for symptoms related to pregnancy induced; i.e., hypertension headaches, edema in face, hands and feet
- Blurred vision
- Right upper quadrant pain
- 24 hour urine results greater than 300 mg of total protein
- Antihypertensive medications
- Pre-pregnancy and current blood pressure readings.
- **Will not be covered** for patients with a diagnosis of chronic hypertension

Only dates the items are actually used are to be billed to the department. No payment is allowed while the patient is in the hospital or absent from her home even though the equipment is still in the home.

Approval of these items will be for no more than one month rental initially. Extension of this initial rental period requires documentation of ongoing medical need.

M-217.3 Hospital Beds

Prior approval is required for payment for all hospital beds. All prior approval requests for a hospital bed must include an [HFS 1409 Prior Approval Request](#) form and the ordering practitioner-completed [HFS 3905 Hospital Bed Questionnaire](#). The participant's height and weight are required. If the participant's weight exceeds 250 pounds, the manufacturer's product information must also be included in the request. The appropriate size of bed must be requested to ensure that the equipment is large enough to accommodate the individual participant.

M-217.3.1 Group 2 Support Surface Mattresses

All Group 2 support surface mattresses require prior approval. All prior approval requests must include an [HFS 1409 Prior Approval Request](#) form and the ordering practitioner-completed [Form HFS 3701G Special Decubitus Mattress Questionnaire](#). An initial three month rental approval will be considered for treatment of Stage III and Stage IV decubitus ulcers for participants living at home.

All requests for renewal beyond the initial three months will require submission of an HFS 1409 along with an updated HFS 3701G that includes the practitioner's assessment for continued need beyond the initial approval.

M-217.3.2 Group 3 Support Surface Mattresses

A request for an air fluidized bed requires submission of a completed [HFS 1409 Prior Approval Request](#) form, an [HFS 2305A Air Fluidized Bed Questionnaire](#), and [HFS 2305 Wound Measurement Assessment Form](#). Prior approval requests for additional rental following the initially approved rental period requires updated clinical status reports, a new HFS 1409, and an updated HFS 2305 Wound Measurement Assessment Form completed no more than seven days prior to submission of the prior approval request.

M-217.4 Osteogenesis Bone Growth Stimulator, Non-Invasive

Purchase of a non-invasive bone growth stimulator requires submittal of an [HFS 1409, Prior Approval Request](#) form. Requests must include certification of medical necessity by an orthopedic surgeon, neurosurgeon, or podiatrist ordering within the limitations circumscribed by the Illinois Medical Practice Act. Medical justification must be consistent with current standards of practice.

Required information must include:

- Date of original injury
- Diagnosis including grading of spondylolisthesis where relevant
- Original, serial, and most recent radiographic reports delineating location and type of fracture and degree of gap at fracture site
- Nature of the precipitating injury
- Operative reports(s), current and previous at same site
- Current risk factors for nonhealing such as nicotine use, chronic renal disease, diabetes mellitus, or chronic oral steroid use
- Serial outpatient progress notes

If the patient is a teenager, a declaration must be made about the skeletal maturity or supply a radiographic report wherein a comment is made specifically about the epiphyseal growth plate either being open or closed at the fracture site proposed for treatment.

If the patient has a pacemaker or other implantable cardiac defibrillator that may be negatively affected by the bone growth stimulator, this must be declared.

M-217.5 Neuromuscular Electrical Stimulator (NMES)

Coverage of NMES is limited to the treatment of muscle atrophy of healthy muscle during or following periods of enforced inactivity when the nerve supply to the muscles to be stimulated is intact including the brain, spinal cord, and peripheral nerves, and there is a non-neurological reason for the disuse atrophy. Requests for a NMES require prior approval. The request must include submission of an [HFS 1409 Prior Approval Request](#) form and a signed and completed [HFS 2305I, Questionnaire and Order for Neuromuscular Electrical Stimulator \(NMES\)](#) to document medical necessity. Use of a NMES is intended as an adjunct to a comprehensive rehabilitation program including physical therapy and not as a substitute for it.

Please submit make, model, and actual acquisition cost for the proposed unit. All supplies and accessories are included in the rental reimbursement of the NMES.

M-217.6 Specialized Wound Therapy

Specialized wound therapies, including but not limited to Negative Pressure Wound Therapy, require approval by the department prior to the start of treatment. Post approval will not be considered for any specialized wound therapies. The following procedures should be followed:

Negative Pressure Wound Therapy (NPWT) requires approval before initiation of this type of wound therapy. Providers new to the NPWT prior approval process should contact the Prior Approval Unit at 217-524-0009 for detailed instructions and additional provider support in requesting prior approval.

Prior approval requests for consideration of an initial month of therapy will require submittal of the following:

- An [HFS 1409 Prior Approval Request](#) form
- an [HFS 3785 Questionnaire for Negative Pressure Wound Therapy](#) completed by the treating practitioner.
- supporting documentation, when applicable, including but not limited to, current history and physical, operative reports, and current wound culture and sensitivity reports
- a body assessment report from initial admission is required for all participants in a long term care facility.

Note: NPWT is not covered outside of the long term care per diem rate when the wound requiring treatment was acquired in that long term care facility or any sister facility.

Renewal requests for review for a second month of therapy must be received within seven days of the end date of service on the initial approval to avoid disruption in approval for reimbursement. Renewal requests will require submittal of the [HFS 1409](#) form and a completed [HFS 3785A Progress Report for Negative Pressure Wound Therapy](#) providing assessment of weekly wound measurements that has been reviewed, certified and signed by the treating practitioner.

Prior approval renewal requests extending beyond a cumulative two-month treatment period will require a higher level of documentation including, but not limited to, a detailed letter from the **treating** practitioner summarizing wound progress, participant compliance and overall management of participant's co-morbid conditions, along with discussion of medical need for continued NPWT.

Note: If the participant is admitted to the hospital during the approved dates of service, the provider must notify the department to end the approval. If NPWT is ordered upon discharge from the hospital, the provider must submit a new prior approval request for review.

M-217.7 Home Phototherapy

An [HFS 1409, Prior Approval Request](#) form must be submitted for home phototherapy along with a completed [HFS 2305H, Questionnaire for Home Phototherapy](#), supporting laboratory documentation, and any available clinical records such as admission history and physical and discharge summary. The rental reimbursement includes caregiver education on proper use of equipment and set-up. Use of the phototherapy unit must be in compliance with appropriate precautions including eye protection when applicable.

M-217.8 Heavy Duty Equipment

[HFS 1409 Prior Approval Requests](#) for heavy duty equipment, including but not limited to, wheelchairs and hospital beds, must include the participant's height, weight and other applicable physical measurements. Providers must also include the manufacturer's product information summarizing the product specifications to ensure equipment is appropriate to accommodate the size of the participant to meet their long term needs.

M-217.9 Compression/Burn Garments

An [HFS 1409 Prior Approval Request](#) form must be submitted for compression/burn garments accompanied by a completed [HFS 2305K Compression/Burn Garments Questionnaire](#). Orders for compression/burn garments must include the following:

- Related diagnosis(es)
- Specification of requested item
- Specification if the garment is to be worn during the day and/or night
- Anatomic area(s) to which the garment is to be applied.
- Units of pressure

Miscellaneous items such as zippers, pockets, and silicone bands will be considered when included in the practitioner order with documentation to support the medical essential need for the item. Items that are primarily for comfort, convenience, or recreation are excluded from coverage.

If a more expensive brand is requested, documentation must be submitted to support why a more cost-effective compression garment is not expected to meet the patient's needs. Absent this documentation, the more cost-effective brand will be considered to arrive at an approved amount. The prior approval request requires submission of the manufacturer's name, product name with item description, and copy of the invoice reflecting actual acquisition cost for the garment.

M-217.10 Not Elsewhere Classified (NEC) or Miscellaneous Items

Providers must use the appropriately assigned HCPCS code when available. If the provider is unable to determine an appropriate HCPCS for an item to be requested, the NEC may be used.

When it is necessary to use an NEC code, the provider must submit the manufacturer's product information describing the requested item along with the manufacturer's invoice displaying the acquisition cost to the provider. In most circumstances, NEC item requests will also require submission of medical documentation specific to the client that supports the medical essential need for the item being requested.

M-218 Limitations and Considerations Regarding Coverage of Items by Other Programs

When a covered participant is eligible for the services of other agencies (State or federal), private insurance or disability compensation, etc., such resources must be billed first. The provider is responsible for determining the status of a participant's coverage and third party liability prior to submitting claims to the department.

If a participant did not inform the provider of his or her eligibility for medical assistance, the claim must be received no later than six months following the date they are informed by the participant. To be considered for exception, documentation of the provider's dated, private-party 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 override approval.

Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, for further information on third party coverage.

M-218.1 Division of Specialized Care for Children (DSCC)

DSCC handles the care coordination of children who have special needs, including children who are medically fragile and technology dependent. The department and DSCC coordinate and adjust their respective policies to avoid duplication of services between the two departments. For children who are eligible in both programs, providers must first request prior approval through HFS. If the item is not approved by HFS, DSCC may consider covering the item.

For HFS coverage of medical equipment and supplies for children who are also eligible for services under DSCC, the item must meet all the requirements described in this handbook, including prior approval. Such items require a valid practitioner order and must meet all other coverage requirements as outlined in this handbook, regardless of the child's inclusion in a DSCC case plan. The DSCC case plan, however, may contain information that will assist in obtaining prior approvals from the department, such as the medical justification for the item, functional prognosis, etc.

M-218.2 Early Intervention (EI)

Illinois' Early Intervention program's mission is to assure that families who have infants and toddlers, birth to three years of age, with diagnosed disabilities, development delays or substantial risk of significant delays, receive resources and support that assist them in maximizing their infants' and toddlers' development.

EI services must be sought first for children in this age group.

Providers billing for EI covered items or services must bill the EI Central Billing Office (CBO) for payment. Contact Early Intervention at 1-800-634-8540 for service questions, and 217-782-1981 for billing questions.

M-218.3 Medicare

For patients with Medicare coverage, charges must be first submitted to Medicare unless the fee schedule indicates the item is not covered by Medicare. The department will consider Medicare's payment on an item or service to be a determination of medical necessity for the item and for the quantity dispensed and paid. If the claim does not crossover automatically from Medicare, providers may bill the department for consideration of co-insurance and deductibles on Medicare-allowed items by submitting Form HFS 3797, Medicare Crossover Invoice. Medicare/Medicaid crossover claims must meet the 24-month timely filing limitation as stated in 89 Illinois Administrative Code section 140.20.

For dates of service July 1, 2015 and after, providers may bill the department for Medicare co-insurance and deductibles for individuals enrolled in a Medicare Advantage Plan (MAP) and Medicaid. HFS will consider cost-sharing when the participant is a Qualified Medicare Beneficiary (QMB) with or without Medicaid full benefits. Additional information regarding the QMB program can be found on the QMB Medicare Savings Programs webpage.

Claims from MAPs do not automatically cross over to the department. Providers must submit claims within the twenty-four (24) month timely filing limit for Medicare crossovers. Providers should review the Explanation of Medicare Benefits to determine if the patient has co-insurance and deductibles. Non-Institutional providers, such as DME providers, are required to submit a paper HFS 3797, Medicare Crossover Invoice or 837P to the department. Claims must be completed in the same manner as original fee-for-service Medicare crossover claims.

Refer to Appendix M-2 for specific instructions on billing Medicare/Medicaid crossover claims.

If Medicare makes a payment on only a portion of the quantity billed, the remaining quantity should be billed on Form HFS 2210, with a copy of the Medicare EOMB and Form HFS 1624 Override Form. If the quantity is over the department's coverage limits for that item, prior approval is required.

Example: If the department allows a quantity of ten per month without prior approval, but the physician orders a quantity of fifteen per month and Medicare allows payment for only three per month, the department will pay co-insurance on the quantity of three. Payment for the remaining twelve items per month would require prior approval. The remaining quantity should be billed on an HFS 2210 for special handling with an HFS 1624 Override Form to override the Medicare edit.

Refer to the Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, for more information on the relationship between the department's coverage and Medicare coverage.

Claims that have been denied by Medicare for which the provider is seeking payment must be submitted on a Form HFS 2210 with a copy of the EOMB and [HFS 1624 Override Form](#). Before submitting a claim to the department, the provider should review the reason for Medicare's denial to determine whether the claim should be submitted. In general, the provider should submit a claim to the department for payment consideration only when the reason for Medicare's denial of payment is either:

- The patient was not eligible for Medicare benefits, or
- The service is not covered as a Medicare benefit.

Provider billing errors and contractual obligations will not be considered for payment.

If the provider requested a reconsideration of Medicare's denial, the department is not to be billed until after Medicare's reconsideration decision.

If charges are denied by Medicare for an item or service for which the department requires prior approval, a post approval request may be submitted but it must have the Medicare EOMB attached to explain the reason for denial. Such requests must be submitted within 90 days following final adjudication by Medicare.

Appropriate and complete documentation (including a copy of Medicare's denial, reason and date of notification) must be submitted with a provider's request for prior approval ([Form HFS 1409](#)), the practitioner's order and documentation of medical necessity. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached. All limitations and requirements in Chapter M-200 apply to these requests.

M-218.4 Women, Infants and Children Program (WIC)

WIC maintains a list of formulas and nutritional supplements that are covered by the Illinois Department of Public Health's WIC Program. The participants eligible for services include infants up to one year; children up to age 5; and women who are pregnant, lactating or up to six months postpartum. Participants must seek benefits from the WIC Program before prior approval of these same items will be considered by the department.

In order for the department to consider prior approval for a WIC covered item, the request must contain a WIC denial letter. The letter must document either the quantity covered by the WIC program, or a statement that an item is not covered by WIC.

The department will consider prior approval of medically essential formulas when:

- The formula is not approved for coverage through the WIC program, or
- The quantity of formula is in excess of the amount provided by the WIC program.
- The client is completely tube fed with no oral intake **and** has the required supporting WIC denial letter.
- A request is received for prior approval for formula until a WIC appointment can be completed to coordinate eligible WIC benefits. A one-month supply will be initially considered with a maximum of two-month supply consideration.

The prior approval request must contain:

- A completed [HFS 1409 Prior Approval Request](#) form
- Documentation of WIC coverage or non-coverage of WIC listed formulas
- A practitioner completed [HFS 3701N Questionnaire for Enteral Nutrition](#) that includes the current, dated, practitioner order for the requested formula.
- Attached documentation of the medical condition which supports the medical need for the formula or for the quantity which exceeds the WIC allowance.

M-270 Long Term Care Facility Services

Long Term Care (LTC) facilities are required to provide medical equipment, devices and supplies commonly used in patient care as a part of the per diem reimbursement paid to the facilities by the department. These items are identified in Appendix M-6.

Prior approval to provide equipment or supply items for an LTC facility resident with an unusual need may be requested when the item is necessary for the continuous care and **exclusive use** of the resident. These items are typically custom made wheelchairs; braces; custom made adaptive equipment; ostomy supplies or hearing aids, but may include other items to meet special patient needs.

Items purchased by the department for the exclusive use of an individual resident become the property of that resident. If the resident is discharged or transferred to another LTC facility, the items must accompany the resident.

Repairs to equipment owned by the LTC facility are not covered. Equipment items are considered owned by the facility, even though they were initially purchased for the exclusive use of an individual resident, if they are subsequently donated to the facility because of the resident's death or because the resident recovers sufficiently that he or she no longer needs the equipment.

Refer to Topic M-214.32 for specific coverage conditions for oxygen for LTC facility residents.

These limitations do not apply to residents of Supportive Living (SLF) facilities or Community Integrated Living Arrangements (CILA). A SLF resident is considered to be residing in his or her own home for purposes of determining coverage for medical equipment and supplies.