**Section 140.413 Limitation on Physician Services**

a) When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services:

1) Termination of Pregnancy. All abortion service claims must be accompanied by an HFS 2390 Abortion Payment Application. The Department will pay for abortion services when:

A) The pregnancy results from rape or incest;

B) In the physician's professional judgment, the pregnancy threatens the life of the mother; or

C) The service is performed for any other reason.

2) Sterilization

A) Therapeutic sterilization – only when the procedure is either a necessary part of the treatment of an existing illness, or is medically indicated as an accompaniment of an operation on the female genitourinary tract. Mental incapacity does not constitute an illness or injury that would authorize this procedure.

B) Nontherapeutic sterilization – only for recipients age 21 or older and mentally competent. The physician must obtain the recipient's informed written consent in a language understandable to the recipient before performing the sterilization and must advise the recipient of the right to withdraw consent at any time prior to the operation. The operation shall be performed no sooner than 30 days and no later than 180 days following the date of the recipient's written informed consent, except in cases of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent was given.

3) Morbid Obesity. Effective October 1, 2012, surgery for morbid obesity is covered only with prior approval by the Department. The Department shall approve payment for this service only in those cases in which the physician determines that obesity is exogenous in nature, the recipient has had the benefit of other therapy with no success, endocrine disorders have been ruled out, and the body mass index (BMI) is 40 or higher, or 35 to 39.9 with serious medical complications. The medical record must contain the following documentation of medical necessity:

A) Documentation of review of systems (history and physical);

B) Client height, weight and BMI;

C) Listing of co-morbidities;

D) Patient participation in a six month consecutive medically supervised weight loss program working in conjunction with a registered dietician and or physician within two years prior to the surgery, with at least four documented visits within the consecutive six months;

E) Current and complete psychiatric evaluation indicating the patient is an appropriate candidate for weight loss surgery; and

F) Documentation of nutritional counseling.

4) Psychiatric Services

A) Treatment – when the services are provided by a physician who has been enrolled as an approved provider with the Department.

B) Consultation – only when necessary to determine the need for psychiatric care. Services provided subsequent to the initial consultation must comply with the requirements for treatment.

C) Group Psychotherapy – payment may be made for up to two group sessions per week, with a maximum of one session per day. The following conditions must be met for group psychotherapy:

i) documentation maintained in the patient's medical record must indicate the person participating in the group session has been diagnosed with a mental illness as defined in the International Classification of Diseases (ICD-9-CM) or, upon implementation, International Classification of Diseases, 10th Revision, Clinical Modification (ICD‑10‑CM), or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). The allowable diagnosis code ranges will be specified in the Handbook for Practitioners Rendering Medical Services;

ii) beginning 1/1/10, the entire group psychotherapy service is directly performed by a physician licensed to practice medicine in all its branches who has completed an approved general psychiatry residency program or is providing the service as a resident or attending physician at an approved or accredited residency program;

iii) the group size does not exceed 12 patients, regardless of payment source;

iv) the minimum duration of a group session is 45 minutes;

v) the group session is documented in the patient's medical record by the rendering physician, including the session's primary focus, level of patient participation, and begin and end times of each session;

vi) the group treatment model, methods, and subject content have been selected on evidence-based criteria for the target population of the group and follows recognized practice guidelines for psychiatric services;

vii) the group session is provided in accordance with a clear written description of goals, methods and referral criteria; and

viii) Effective July 1, 2012, group psychotherapy is not covered for recipients who are residents in a facility licensed under the Nursing Home Care Act [210 ILCS 45] or the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49].

5) Home Services. Services provided to a recipient in his or her home – only when the recipient is physically unable to go to the physician's office.

6) Services provided to recipients in group care facilities by a physician other than the attending physician – only for emergency services provided when the attending physician of record is not available or when the attending physician has made referral with the recipient's knowledge and permission.

7) Services provided to recipients in a group care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit in the facility) – only when occasioned by an emergency due to acute illness or unavailability of essential treatment facilities in the vicinity for short-term care pending transfer, or when there is no comparable facility in the area.

8) Maternity Care. Payment shall be made for pre-natal and post-natal care only when the following conditions are met:

A) the physician, whether based in a hospital, clinic or individual practice, retains hospital delivery privileges, maintains a written referral arrangement with another physician who retains such privileges, or has been included in the Maternal and Child Health Program as a result of having entered into an appropriate Healthy Moms/Healthy Kids Program provider agreement;

B) the written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; and

C) maternal services are delivered in a manner consistent with the quality of care guidelines published by the American College of Obstetricians and Gynecologists in its Guidelines for Women's Health Care (2014) and Guidelines for Perinatal Care (2017), available at 409 12th Street, S.W., Washington D.C. 20024-2188, or at https://www.acog.org.

9) Physician Services to Children under Age 21

A) Payment shall be made only when the physician meets one or more of the following conditions. The physician:

i) has admitting privileges at a hospital;

ii) is certified or is eligible for certification in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties;

iii) is employed by or affiliated with a Federally Qualified Health Center;

iv) is a member of the National Health Service Corps;

v) has been certified by the Secretary of the Department of Health and Human Services as qualified to provide physician services to a child under 21 years of age;

vi) has current, formal consultation and referral arrangements with a pediatrician or family practitioner for the purposes of specialized treatment and admission to a hospital. The written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; or

vii) has entered into a Maternal and Child Health provider agreement or has otherwise been transferred in from the Healthy Moms/Healthy Kids Program;

B) The physician shall certify to the Department the way in which he or she meets the criteria of subsection (a)(9)(A); and

C) Services to children shall be delivered in a manner consistent with the standards of the American Academy of Pediatrics and rules published by the Illinois Department of Public Health (77 Ill. Adm. Code 630, Maternal and Child Health Services; 77 Ill. Adm. Code 665, Child Health Examination Code; 77 Ill. Adm. Code 675, Hearing Screening; 77 Ill. Adm. Code 685, Vision Screening).

10) Hysterectomy. Only if the individual has been informed, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing and the individual has signed a written acknowledgment of receipt of the information. The Department will not pay for a hysterectomy that would not have been performed except for the purpose of rendering an individual permanently incapable of reproducing.

11) Selected Surgical Procedures. Includes:

A) tonsillectomies or adenoidectomies;

B) hemorrhoidectomies;

C) cholecystectomies;

D) disc surgery/spinal fusion;

E) joint cartilage surgery/meniscectomies;

F) excision of varicose veins;

G) submucous resection/rhinoplasty/repair of nasal system;

H) mastectomies for non-malignancies; and

I) surgical procedures that generally may be performed in an outpatient setting (see Section 140.117), but only if the Department authorizes payment. The Department will in some instances require that a second physician agree that the surgical procedure is medically necessary prior to approving payment for one of these procedures. The Department will require a second opinion when the attending physician has been notified by the Department that he or she will be required to obtain prior approval for payment for the surgeries listed. (See Sections 140.40 through 140.42 for prior approval requirements.) The Department will select physicians for this requirement based on the recommendation of a peer review committee that has reviewed the utilization pattern of the physician.

12) Mammography Screening and Related Services. Described in 305 ILCS 5/5-5.

13) Pap Tests and Prostate-Specific Antigen Tests. Coverage is provided for the following:

A) An annual cervical smear or Pap smear test for women.

B) An annual digital rectal examination and a prostate-specific antigen test, upon the recommendation of a physician licensed to practice medicine in all its branches, for:

i) asymptomatic men age 50 and over;

ii) African-American men age 40 and over; and

iii) men age 40 and over with a family history of prostate cancer.

14) Coronary Artery By-Pass Grafts. Effective July 1, 2012, coronary artery by-pass grafts are covered only with prior approval by the Department.

15) Tobacco Cessation Counseling. Face-to-face tobacco cessation counseling only for pregnant and up to 60‑day postpartum women age 21 and over. The tobacco cessation counseling services:

A) Must be provided by or under supervision of a physician, or by any other health care professional who is legally authorized to furnish those services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services.

B) Are limited to a maximum of three quit attempts, with four individual face-to-face counseling sessions per quit attempt, per calendar year.

C) Must be properly documented in the patient's medical record and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources available and follow-up. Distinct documentation to support this service is required if reported in conjunction with another evaluation and management service.

D) Rendered to participants under age 21 are not subject to the limitations in this subsection (a)(15).

16) Gender-affirming Surgeries, Services and Procedures

A) Gender-affirming surgeries, services and procedures are covered only with prior approval by the Department for individuals who are 21 years of age or older. In order for prior approval to be granted for genital surgeries, letters from two qualified medical providers must be submitted, including one from a Licensed Practitioner of the Healing Arts (LPHA), as defined in Section 140.453(b)(3)(A) through (D) and (F), and one from either the individual's primary care physician or the physician managing the individual's gender-related healthcare. In order for prior approval to be granted for non-genital surgeries, one letter from either the individual's primary care physician or the physician managing the individual's gender-related healthcare must be submitted. The qualified medical provider or providers must have independently assessed the individual and must be referring the individual for the surgery. Together, the letter or letters must establish:

i) That the individual:

● has a diagnosis of gender dysphoria;

● has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless that therapy is medically contraindicated or the individual is otherwise unable to take hormones;

● has lived continuously for at least 12 months in the gender role that is congruent with their gender identity, in the case of an individual seeking genital surgery;

● has completed an assessment by an LPHA, as defined in Section 140.453(b)(3)(A) through (D) and (F), which must include education and counseling of treatment options and implications; and psychotherapy, if indicated;

● if a significant medical or mental health condition is present that would be a contraindication to the gender-affirming surgery, service or procedure, it must be reasonably well-controlled; and

● has the capacity to make a fully informed decision and to consent to the treatment;

ii) That the medical provider has communicated with the individual's other medical providers regarding the proposed surgery, service or procedure;

iii) The medical necessity of the surgery, service or procedure; and

iv) Recommendations for post-operative care.

B) The Department will cover all gender-affirming surgeries, services and procedures that are medically necessary to treat a particular individual's gender dysphoria and are listed on the Department's fee schedule and in the Practitioner Handbook. Gender-affirming surgeries, services and procedures shall include, but are not limited to, breast/chest surgeries, genital surgeries, and related therapies.

C) If prior approval is for genital surgery, the surgery must be performed by a urologist, gynecologist, or plastic or general surgeon who is board-certified in the practitioner's area of expertise and has demonstrated specialized competence in gender-based genital reconstruction as indicated by documented supervised training or post-graduate training in the field of gender-based genital reconstruction.

D) Surgeries resulting in sterilization must meet all requirements of subsection (a)(2); surgeries performed for the purpose of treating gender dysphoria are considered therapeutic sterilizations for purposes of this Section.

E) Notwithstanding the age limitation in subsection (a)(16)(A), payment for gender-affirming surgeries, services and procedures for patients under 21 years of age will be made in specific cases if medical necessity is demonstrated and prior approval is received.

b) In cases in which a physical examination by a second physician is needed, the Department will notify the recipient and designate a physician to perform the examination. Physicians will be subject to this requirement for six months, after which a request can be submitted to the peer review committee to consider removal of the prior approval requirement.

(Source: Amended at 44 Ill. Reg. 226, effective December 23, 2019)