**Section 140.462 Covered Services in Clinics**

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-Based Organized Clinics. Covered services are those described in 89 Ill. Adm. Code 148.

b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924, covered services are those described in Section 140.922.

2) With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.

3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

c) Rural Health Clinics

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Group Psychotherapy Services – 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:

A) 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 9th Revision, Clinical Modification (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;

B) beginning February 1, 2013, the entire group of psychotherapy services must be directly performed by one of the following practitioners:

i) 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;

ii) an Advanced Practice Registered Nurse holding a current certification in Psychiatric and Mental Health Nursing as set forth in 68 Ill. Adm. Code 1305.Appendix A;

iii) Psychologist;

iv) Licensed Clinical Social Worker;

v) Licensed Clinical Professional Counselor; or

vi) Licensed Marriage and Family Therapist;

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

D) the minimum duration of the group session is 45 minutes;

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

F) 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;

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

H) 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 [210 ILCS 48].

3) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).

4) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) speech and hearing services;

I) x-ray services;

J) health education;

K) nutrition services;

L) optometric services.

5) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

6) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.

7) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services with the exception of services identified in subsections (c)(8) and (c)(9).

8) Effective July 1, 2012 through June 30, 2013, a physician or APRN may submit fee-for-service billings for implantable contraceptive devices administered in an RHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) The RHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

9) Effective July 1, 2013, an RHC may submit fee-for-service billings for Long Acting Reversible Contraceptives (LARCs). For dates of service October 1, 2014 and after, an RHC may submit fee-for-service billing for non-surgical transcervical permanent contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the LARCs or transcervical permanent contraceptive devices were purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

10) Tobacco cessation counseling services may be billed as an encounter if furnished by a provider as defined in Section 140.413(a)(15) within the designated coverage limitations.

d) Federally Qualified Health Centers

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Group Psychotherapy Services – 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:

A) 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 9th Revision, Clinical Modification (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;

B) beginning February 1, 2013, the entire group of psychotherapy services must be directly performed by one of the following practitioners:

i) 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;

ii) an Advanced Practice Nurse holding a current certification in Psychiatric and Mental Health Nursing as set forth in 68 Ill. Adm. Code 1305.Appendix A;

iii) Psychologist;

iv) Licensed Clinical Social Worker;

v) Licensed Clinical Professional Counselor; or

vi) Licensed Marriage and Family Therapist;

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

D) the minimum duration of the group session is 45 minutes;

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

F) 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;

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

H) 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 [210 ILCS 48].

3) Other services for which separate encounters may be billed include:

A) dental services provided by a dentist or a dental hygienist, as defined and in accordance with the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center; and

B) behavioral health services as defined in Section 140.463(a).

4) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) optometric services;

I) speech and hearing services;

J) x-ray services;

K) health education;

L) nutrition services.

5) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.

6) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

7) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided with the exception of services identified in subsections (d)(8) and (d)(9).

8) Effective July 1, 2012 through June 30, 2013, a physician or APRN may submit fee-for-service billings for implantable contraceptive devices administered in an FQHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) The FQHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

9) Effective July 1, 2013, an FQHC may submit fee-for-service billings for LARCs. For dates of service October 1, 2014 and after, an FQHC may submit fee-for-service billing for non-surgical transcervical permanent contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the LARCs or transcervical permanent devices were purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

10) Tobacco cessation counseling services may be billed as an encounter if furnished by a provider as defined in Section 140.413(a)(15) within the designated coverage limitations.

e) School Based/Linked Health Clinics (Centers)

Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(f):

1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 43 Ill. Reg. 4094, effective March 25, 2019)