

ILLINOIS DEPARTMENT OF HUMAN SERVICES
Division of Mental Health
Provider Manual

Coordination of Benefits – Provider Requirements

The Provider is responsible for determining whether the individual or family has private or public benefits that can pay for services. The Provider shall assist individuals and their families in applying for any benefits for which they may be eligible. This may include using a screening tool to evaluate the potential for any individual to become eligible for Medicaid or AllKids benefits. The Provider shall document in the individual's record the Provider's assessment for entitlement eligibility, their efforts to assist in the application process, and, if applicable, when an application for such benefits has been made to the Department of Human Services, the Department of Healthcare and Family Services (HFS), the Veteran's Administration, or the Social Security Administration. When an individual is provided a billable service under this contract and the Provider determines that the individual has other resources for payment, the Provider is to follow these procedures for submitting a bill:

- 1) The Provider will determine if there are other liable third parties for payment, other than the individual or the individual's family, and will bill those third parties first;
- 2) The Provider will bill HFS for the service at the Provider's usual and customary rate;
- 3) The Provider will report on the claim submitted to HFS required information on the consumer's third party payment status, the code or name of the primary liable third party, and the amount of any third party payments received for the service or anticipated to be received (if the actual amount received differs, the Provider shall resubmit the bill with the correct amount actually received);
- 4) DHS/DMH will then price the claim and pay the lower of the following:
 - a. The Provider's usual and customary charge for the service minus the sum of all third party payments, or
 - b. The established DHS/DMH rate for the service minus the sum of all third party payments and/or adjusted based on allowed DHS/DMH payment based on household income and size.
- 5) The Provider shall maintain documentation of household income and size, and all activities related to the identification, billing, and collection of payments from third party payers for each consumer. Documentation is subject to retrospective and post payment review by DHS/DMH or its agent.
- 6) The HFS Integrated Care program is considered as a payor with full clinical and financial responsibility for all services necessary for their enrollees. When an individual is provided a

billable service, the full and total liability for that service rests with the Integrated Care contractor (HMO). The Provider shall determine and document that costs for those services are fully and totally reimbursed by the integrated care provider. The Provider shall maintain documentation of all activities related to the identification, billing, and collection of payments from the integrated care contractor for each Integrated Care enrollee/consumer. DHS/DMH Capacity Grant funds may be used to provide capacity services for ICP Enrollees. In the event that the ICP entities begin making payments for capacity services, no additional funding will be provided by DMH for these services and providers must follow the guidance above for these services.