

- The Division of Specialized Care for Children (DSCC) operates the Home Care Program on behalf of the Department of Healthcare and Family Services (HFS). DSCC requires claims be received no later than twelve (12) months following the provision of services including insurance payment or denial information. Claims not received within this time frame will not be eligible for payment.
- Dates of service billed must be in accordance with the standard billing week which begins Sunday at 12:00 a.m. and ends Saturday at 11:59 p.m.
- Claims can not be submitted to DSCC until all weekly timesheets have been received for all nursing shifts worked for the standard billing week.
- The normal billing day is 12:00 a.m. to 11:59 p.m. Nursing hours are to be reported on the calendar day they are worked. EXAMPLE: When a shift is from 11:00 p.m. to 7:00 a.m., 11:00 p.m. to 11:59 p.m time must be listed on one calendar day and the remaining hours reported on the following calendar day.
- Hours from individual work shifts for the same date of service are to be combined by procedure code prior to submitting claims for the standard billing week. EXAMPLE: If an RN worked 7-3 and another RN worked 11-12, enter 36 units T1002.
- Respite hours are to be billed and submitted at the end of the billing week after the child has exhausted the approved regular hours for a respective week.
- Billing rates cannot exceed the rates approved by HFS. Requests for changes in the hourly rate must be submitted in writing to the DSCC Care Coordinator and will be sent to HFS for consideration.
- HFS is payer of last resort minus any hours paid by primary insurance or another agency.
- When nursing hours are paid by the school, these hours must be subtracted from the approved number of nursing hours for the week.
- The nursing agency or family is responsible for submitting claims to the insurance company. Payment for approved nursing services in accordance with the Medical Plan of Care for children shall not be made until insurance has paid or rejected the claim.
- Claims should be submitted with a copy of the insurance carrier's Explanation of Benefits (EOB) as soon as insurance determination has been received. Claims where insurance payments exceed the rates approved by HFS will be considered paid in full.
- Verification of services provided must be documented, signed by the client, and nurse or certified nurse assistant and maintained by the agency for review upon request.
- Verify all information and calculations are correct.
- **Claims submitted that are not in accordance with the billing requirements will be returned to the provider to make the appropriate corrections and will delay payment.**



**WEEKLY BILLING
FOR HOME NURSING**

DIVISION OF SPECIALIZED CARE
FOR CHILDREN

1. PROVIDER NAME

2. PROVIDER NUMBER

3. PROVIDER INVOICE NO.

4. PROVIDER BILLING ADDRESS

5. CITY, STATE, ZIP

6. CHILD'S NAME (FIRST, MI, LAST)

7. SITE ADDRESS (CITY, STATE, ZIP)

8. PRIOR APPROVAL

9. RECIPIENT NUMBER

10. DSCC NUMBER

11. BIRTHDATE

12. SERVICE SECTIONS

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

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PROCEDURE DESCRIPTION

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MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

15. CERTIFICATION:

By signature I certify the above billing is an accurate report of service hours rendered and hourly rates billed are in accordance with the Medical Plan of Care approved by Illinois Department of Healthcare and Family Services. All services billed were provided by nurses with a valid Illinois license or home health aide certified by the State of Illinois. Verification of services billed must be documented through the time sheets and nursing notes which must be maintained by your Agency for review upon request.

Signature

Date

13. TOTAL CHARGES

14. TOTAL DEDUCTIONS

SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE FORWARD ALL BILLINGS, INSURANCE CARRIER'S EXPLANATION OF BENEFITS AND QUESTIONS TO:

Division of Specialized Care for Children	Toll Free	(877) 791-5170
Claims Services Unit	Fax	(217) 558-0773
3135 Old Jacksonville Road	Springfield Area	(217) 558-2350
Springfield, Illinois 62704-6488	TTY (217)	785-4728

“WEEKLY BILLING FOR HOME NURSING” INSTRUCTIONS:

Please type or print all claims. More than one billing form may be required to submit all charges for the standard billing week.

1. **Provider Name:** Enter the provider's name exactly as it appears on the HFS Provider Information Sheet.
2. **Provider Number:** Enter the twelve digit Provider Key Number exactly as it appears on HFS Provider Information Sheet.
3. **Provider Invoice No.:** Enter up to ten numbers or letters used in your billing system for claim identification. If this field is completed it will print on DSCC's Provider Explanation of Benefits.
4. **Provider Billing Address:** Enter the billing street address for the agency. (This is the address where payment will be sent.)
5. **City, State, Zip:** Enter city, state and zip code of "Provider Billing Address" above.
6. **Child's Name (First, MI, Last):** Enter the child's name for services being billed.
7. **Provider Site Address (City, State, Zip):** Enter site address, city, state and zip code where the Provider is located.
8. **Prior Approval:** Leave blank.
9. **Recipient Number:** Enter the nine digit HFS recipient number assigned to the child. Use no punctuation or spaces.
10. **DSCC Number:** Enter the six digit DSCC case number assigned to the child.
11. **Birth date:** Enter the child's month, day and year of birth. Use the MMDDYY format.
12. **Service Sections:**
 - Procedure Description – Enter description of the service performed.
 - Proc Code – Enter the five-digit procedure code for service being billed.
 - Modifiers – Enter the appropriate alpha code to identify the type of nursing hours for respite or training hours.
 - Date of Service – Enter the date the service was performed. Use MMDDYY format.
 - Units/Qty – Enter the total number of 15-minute units worked per day. Combined units of all nursing levels (RN, LPN, HHA) cannot exceed 96 units per day.
 - Insurance Amt – Enter the amount paid by insurance for date of service as indicated on insurance carrier's EOB. Insurance carrier EOB must be attached.
 - Provider Charge – Enter the total charge for individual date of service. Do not deduct any insurance payments in this area.
 - Repeat Box: Enter "X" to repeat information. The repeat indicator may be used to minimize repeated information in the Service Sections. The date of service must be entered in every service section.
 - Total Charges:** Enter the total charge for each page of the billing form.
13. **Total Deductions:** Enter total insurance benefits paid applicable to the billing period. Insurance carrier EOB must be attached.
14. **Certification:** Signature of person certifying the billing form and date signed.

PROCEDURE CODES:

HCPC CODE	MODIFIER	DESCRIPTION	UNITS/MAX UNITS
T1002		Regular RN	15 minute each unit / max 96 units per day
T1003		Regular LPN	15 minute each unit / max 96 units per day
T1004		Regular HHA	15 minute each unit / max 96 units per day
T1005	TD	Respite RN	15 minute each unit / max 96 units per day
T1005	TE	Respite LPN	15 minute each unit / max 96 units per day
S5150		Respite HHA	15 minute each unit / max 96 units per day
S5116	TD	Training RN	15 minute each unit / max 96 units per day
S5116	TE	Training LPN	15 minute each unit / max 96 units per day
T2027		Day Care	15 minute each unit / max 96 units per day