ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

HFS LTC Billing Resources

July 31, 2019

Agency Roles and Responsibilities

- State agencies and Managed Care entities play related but separate roles in approving payment to providers for long term care (LTC) services.
- It is important to understand the various responsibilities so questions can be directed to the proper entity.
- The following pages list the responsibilities of HFS, DHS, MCOs and the MEDI help desk.

Agency Roles and Responsibilities

- Department of Human Services – LTC Hubs
  - Are responsible for determining Medicaid eligibility and eligibility for LTC services for residents of Nursing Facilities (NFs) and Supportive Living Providers (SLPs). They determine the eligibility segments, admission segments and patient credit amounts that ultimately reside in the State's payment processing system (MMIS).
  - Any questions related to a resident's Medicaid eligibility, approval for LTC services or patient credit amount should be sent to the appropriate DHS LTC hub.

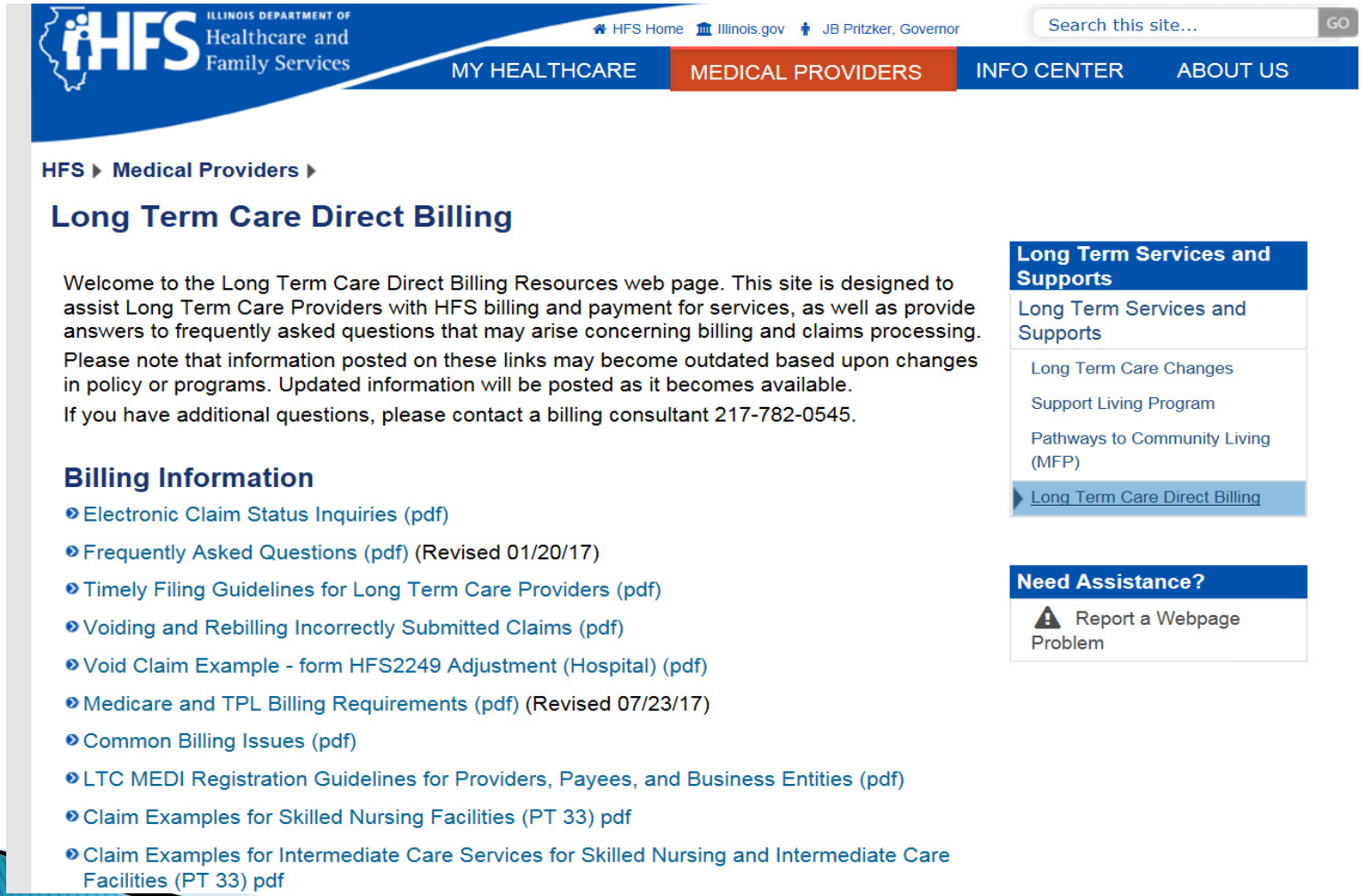
Agency Roles and Responsibilities

- Healthcare and Family Services – BLTC
  - The Bureau of Long Term Care billing unit assists providers with billing, claims processing and payment questions regarding fee-for-service claims paid by the Illinois Comptroller.
  - BLTC also provides assistance with the submittal of transactions through MEDI.
  - Finally, BLTC is responsible for determining Provisional Eligibility for residents of NFs and SLPs that do not have their eligibility determined timely.
  - Questions regarding how to submit claims, proper claim coding, why claims reject, how to submit a MEDI transaction, or why a resident has not been given Provisional Eligibility should be sent to HFS BLTC.

Agency Roles and Responsibilities

- HFS – Bureau of Managed Care
  - Oversees the contracts with MCOs.
  - Has a provider complaint portal to address provider issues that cannot be reconciled with the MCO.
- MEDI Help Desk
  - Addresses issues specific to the functioning of the MEDI system, including login assistance.
  - Providers should call the MEDI Help Desk when they are having problems accessing the MEDI system.
- Managed Care Organizations (MCOs)
  - An MCO will be responsible for addressing provider billing, claims processing and payment questions specific to residents enrolled in their MCO during the date of service being billed.

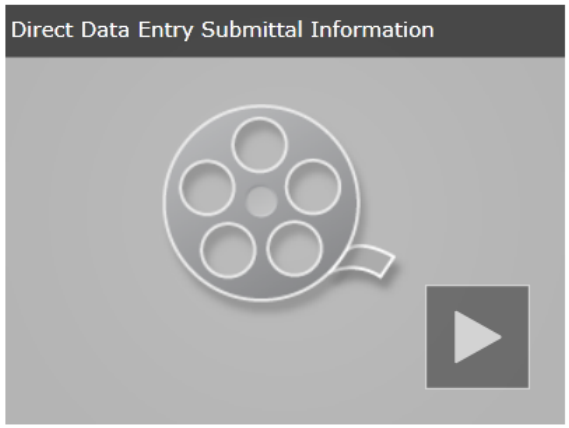
HFS Online Billing and Claims Processing Resources – Direct Billing Page



HFS Online Billing and Claims Processing Resources – Direct Billing Page

- Claim Examples for Intermediate Care Services for Skilled Nursing and Intermediate Care Facilities (PT 33) pdf
- Claim Examples for Intermediate Care Services for Intellectually Disabled (IID) (PT 29) pdf
- Claim Examples for Supportive Living Program Facilities (SLP) (PT 28) pdf
- Claim Examples for Nursing Facilities eligible to be licensed Specialized Mental Health Rehabilitation Facilities (SMHRF) (PT 38) pdf
- Patient Roster Report Specifications (pdf)
- Patient Roster Report Instructions (pdf)

Direct Data Entry (DDE) Submittal Information



HFS Online Billing and Claims Processing Resources – Direct Billing Page

Webinars

Webinar April 9, 2019

- MCDD Reimbursement Effective April 1, 2019 (pdf)

Webinar May 18, 2016 (Revised 01/20/17)

- Long Term Care Service Billing Requirements and Coding (pdf)

Webinar May 4, 2016 (Revised 01/20/17)

- Electronic Claims Submission of Long Term Care Services Claims as Direct Date Entry and Up Loaded File (pdf) (audio)

Webinar April 27, 2016 (Revised 01/20/17)

- Introduction to the New Electronic Claims Processing of Long Term Care Services (pdf) (audio)
- Provider Notice COS Crosswalk Updated 03/27/2017 (xlsx)

Links

- HIPAA 5010 - Health Care Claim: Institutional (837I)
- Medical Electronic Data Interchange (MEDI)
- Provider Enrollment (IMPACT)
- Provider Handbooks

HFS Online Billing and Claims Processing Resources – Provider Handbooks

HFS ▸ Medical Providers ▸

Provider Handbooks

The intent of Provider handbooks is to furnish Medicaid providers with policies and procedures needed to receive reimbursement for covered services, funded or administered by the Illinois Department of Healthcare and Family Services, which are provided to eligible Illinois Medicaid participants. The handbooks provide detailed descriptions and instructions about covered services as well as billing instructions.

Providers are responsible for compliance with all policy and procedures contained herein.

Chapter 100 contains general policy, procedures and appendices applicable to all participating providers.

Chapter 200 contains specific policy, procedures and appendices applicable to the provision of a specific type of provider or category of service (specialty/subspecialty).

Chapter 300 - Companion Guide Information contained in Chapter 300 is a supplement to the X12 (5010) or NCPDP (5.1 or 1.1 batch) Implementation Guides. This handbook contains the companion guides for all providers who will be submitting X12 or NCPDP electronic transactions to the department.

Managed Care Manual - This manual contains helpful information regarding the Medicaid managed care program for providers enrolled in Medicaid.

Additional Resources for Providers

- Handbook Supplement (pdf)
- TPL Code Directory (pdf)
- PBM-TPL Code Directory (xls)
- Error Codes (xls)

Medical Provider Handbooks

- Chapter 100
- Chapter 200
- Chapter CMH-200
- Chapter D-200
- Chapter HK-200
- Chapter U-200
- Chapter 300 Companion Guide 5010 - Electronic Processing

Need Assistance?

⚠ Report a Webpage Problem

HFS Online Billing and Claims Processing Resources – Provider Handbooks Companion Guide

HFS ▸ Medical Providers ▸ Medical Provider Handbooks ▸

Chapter 300 Companion Guide 5010 - Electronic Processing

Table of Contents Basic Provisions

Transactions

- 270/271 - Health Care Eligibility Benefit Inquiry and Response (pdf)
- 276/277 - Health Care Claim Status Request and Response (pdf)
- 835 - Health Care Claim Payment/Advice (pdf)
- Institutional - 837I (pdf)
- Professional - 837P (pdf)
- Managed Care Organizations (pdf)
- NCPDP (pdf)

Reference

- EDI Control (Packaging/Enveloping of Transmissions) (pdf)
- Edits and Rejections (pdf)
- Illinois Medicaid NCPDP Version D.0 Payor Sheet (pdf)
- Illinois Medicaid NCPDP Version E1 Payor Sheet (pdf)
- Taxonomy for 837I
- Taxonomy for 837P

Medical Provider Handbooks

- Chapter 100
- Chapter 200
- Chapter CMH-200
- Chapter D-200
- Chapter HK-200
- Chapter U-200
- Chapter 300 Companion Guide 5010 - Electronic Processing

Need Assistance?

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Resident Status Files to Download from MEDI

- Providers can access two separate files, that list residents approved for Medicaid billing, through the MEDI IEC download functionality.
  - The Resident (Patient) Roster file lists all residents approved for Medicaid LTC billing for the month prior to the run date of the roster.
  - The Patient Credit file, which is also sent to the MCOs on a weekly basis, lists residents approved for LTC services that are enrolled in an MCO. Claims for Medicaid covered services during the MCO enrollment period should be directed to the MCO for payment consideration.

Resident Status Files to Download from MEDI – Process

1. Login to MEDI
2. Select Internet Electronic Claims (IEC)
3. Select Download File(s)
4. Choose the “Entity” from the drop down box
5. Select the file you wish to down load from the “Available Files” listed
6. Enter a “Local Directory Location” (a folder created on your computer or network) to accept the downloaded file
7. Click “Download Files” button
8. Go to your designated directory location
9. Open the downloaded file (recommended program is WordPad)

Resident (Patient) Roster File

patient roster.txt

MEDICAID SYSTEM(MMIS)
RUN DATE: 07/03/2019
LTC SUBSYSTEM
RUN TIME: 13:59:26
REPORT ID: 27363301
SEQUENCE: PROVIDER NUMBER,RECIPIENT NAME
PAGE: 1

STATE OF ILLINOIS

HEALTHCARE AND FAMILY SERVICES
LTC PATIENT ROSTER FOR 06/01/19-06/30/19

LTC FACILITY NUMBER: NAME:

RECIPIENT NUMBER	RECIPIENT NAME	ELIGIBILITY BEGIN DATE	ELIGIBILITY END DATE	ADMISSION DATE	DISCHARGE DATE	DISCHARGE DESTINATION
		01/01/2018	99/99/9999	12/22/2016	00/00/0000	

MCO PLAN ID: 280016 MCO PLAN NAME: BLUE CROSS/BLUE SHIELD OF ILLI
MCO EFFECTIVE DATE: 01/01/2019 MCO END: 99/99/9999
THIS RECIPIENT IS ENROLLED IN MEDICARE PART A
THIS RECIPIENT IS ENROLLED IN MEDICARE ADVANTAGE

		03/25/2019	99/99/9999	03/25/2019	00/00/0000	

THIS RECIPIENT IS ENROLLED IN MEDICARE PART A
LTC PROVISIONAL ELIGIBILITY

Patient Credit File

Data Element	Description/Rules	Data Type	Data Length	Starting Position	Ending Position
Recipient Identification Number	Recipient ID Number	Varchar	9	1	9
Recipient Last Name	Clients Last Name	Varchar	14	10	23
Recipient First Name	Clients First Name	Varchar	9	24	32
Long Term Care Provider Number	LTC Facility ID	Varchar	12	33	44
Hospice Provider Number	Hospice Provider Number	Varchar	12	45	56
Patient Credit Begin Julian Date	Patient Credit Effective Date CCYYDDD	Date	7	57	63
Patient Credit End Julian Date	Patient Credit End Date CCYYDDD	Date	7	64	70
Patient Credit Amount	Patient Credit Amount 0000000.00	Numeric	9	71	79
Level of Care Category of Service	LTC Level of Care Category of Service Code	Varchar	3	80	82
Level of Care Effective Date	LTC Level of Care Begin Date CCYYDDD	Date	7	83	89
Level of Care End Date	LTC Level of Care End Date CCYYDDD	Date	7	90	96
MCO Project Code	Managed Care Project Code	Varchar	2	97	98
MCO Plan Type Code	Managed Care Plan Type Code	Varchar	1	99	99
Filler	Spaces	Varchar	1	100	100

LTC Transaction Report
HFS 2449A

STATE OF ILLINOIS
HEALTHCARE AND FAMILY SERVICES

MEDICAID SYSTEM (MMIS) RUN DATE: 07/29/19
LTC SUBSYSTEM RUN TIME: 00:55:55
REPORT-ID: A2736P11 PAGE: 3

LTC TRANSACTION REPORT BY FACILITY

FACILITY ID/NAME:

RECIP ID/NAME:

FACILITY INFORMATION TRANS TYPE: DIS TRANS DATE: 07/25/19 TRANS SOURCE: LO

	ADM DATE	DIS DATE	DEST
OLD	04/01/15		
NEW	04/01/15	02/28/19	D9

LEVEL OF CARE DATA: TRANS TYPE: COR TRANS DATE: 07/25/19 TRANS SOURCE: LO

	EFF DATE	CLOSE DATE	COS
OLD	04/01/15		073
NEW	04/01/15	02/28/19	073

HFS Paper Remittance Advice

PROVIDER NUMBER	TYPE	ILLINOIS DEPARTMENT OF PUBLIC AID REMITTANCE ADVICE	DATE	PAGE
	33		07/24/19	1

VENDOR COPY

DOCUMENT CONTROL NUMBER RECIPIENT NAME	PROV.REFERENCE RECIPIENT NUMBER	CAT SERV	DATE OF SERVICE	NDC/ITEM OR SERVICE	AMOUNT BILLED	AMOUNT ALLOWED	STAT	ERROR CODES
	RECONCILABLE							
	ADJUDICATED INVOICES							
920090026438	292489		040119 041919		1877.96	.00	RJ	
	VALUE CODE INCONSISTENT WITH STMT PERIOD							L23
	CATEGORY OF SERVICE 70 SUMMARY							
	TOTAL BILLED					1877.96		
	REJECTED					1877.96		
	SUSPENDED					.00		
	TPL REPORTED					.00		
	RETURNED CHECKS					.00		
	CREDITS POSTED					.00		

Timely Filing Guidelines for Claims

- **Timely Filing Guidelines for Long Term Care Providers**
  - Submittal of claims must be in accordance with 89 Ill. Adm. Code 140.20. Claims for Long Term Care Providers are subject to a timely filing deadline of 180 days from the statement through date of the claim. Timely filing applies to both initial and re-submitted claims following prior rejection. Timely filing deadlines are not extended based on a previously rejected claim.
- **Exceptions to the 180 day timely filing requirement**
  - For individuals with pending eligibility during the dates of service, the timely filing deadline is 180 days from the Department of Human Services caseworker's initial processing of the admission into the HFS payment system. Long Term Care Providers can submit a LTC Inquiry transaction through LTC links in MEDI to view admissions that have been processed. Providers are notified of processed admissions via the HFS 2449A Daily Transaction Report.
  - For Medicare primary claims, the timely filing deadline is 24 months from the statement through date of the claim adjudicated by Medicare or Medicare Advantage Plan.

Timely Filing Guidelines for Claims

- **Exceptions to the 180 day timely filing requirement**
  - For claims in which the Department is not the primary payer, the timely filing deadline is 180 days from the adjudication date of a payment made by a primary payer other than Medicare or a Medicare Advantage Plan.
  - For a service period for which a previous claim was voided, the void transaction DCN must be within 12 months of the original paid voucher date for the resubmitted claim to be considered for payment. The resubmission of a claim for the service period previously voided must be received within 90 days from the date of the remittance advice reporting the posting of the void. Please note that the purpose of voiding and rebilling a previously paid claim is to correct errors on the claim (e.g. incorrect number of leave of absence days billed, change in the number of Medicare covered days, etc.) and not for the purpose of billing additional Medicaid covered days.
  - Due to the timely filing requirements, the Bureau of Long Term Care recommends that providers follow up on claim submissions within three business days from the claim submittal. Providers can verify the acceptance of submitted claims via the Claim Status Inquiry function in the MEDI Internet Electronic Claims Application.

Common Billing Issues

- **Common Billing Issues**
- There are fields within the X12 claim that the HFS system requires to be submitted in capitalized letters, such as the whole payer name and any letter in the Taxonomy Code. To avoid rejections, HFS strongly suggests that all entries submitted in an X12 format be capitalized.
- The payer name reported in loop 1000B NM103 must be 'ILLINOIS MEDICAID'.
- The payer ID reported in loop 1000B NM109 must be '37-1320188'.
- The provider name on the claim must be in all capitalized letters and spelled exactly as it appears on the IMPACT system and provider information sheet.
- When a resident of a skilled nursing facility has Medicare Part A coverage:
  - Medicare must be reported as the primary payer (TPL code 909) unless billing a Non-Medicare covered service.
  - When billing a Non-Medicare covered service (legacy category of service code '70') and using a skilled nursing Type of Bill 21X, an Occurrence Code with associated date indicating the date Medicare Exhausted/Ended (A3 or 22) or the date Medicaid began (A2) must be reported on the claim.
  - When billing a Non-Medicare covered service (legacy category of service code '71') and using an intermediate Type of Bill 65X, no additional coding is needed.
- Medicare Coinsurance days reported in Value Code 82 must also be reported as Covered Days in Value Code 80.

Common Billing Issues

- When submitting a claim to Medicare include the billing provider taxonomy code on the claim to assist in the crossover process to the department.
- When using Type of Bill Frequency 1 (Admit through Discharge Claim) or 2 (Interim – First Claim) the admission date on the claim must be the same date as the service from date.
- When using Type of Bill Frequency 3 (Interim- Continuing Claim) or 4 (Interim- Last Claim) the admission date on the claim must be prior to the service from date.
- If a Discharge Status Code of 20 or 30 is reported on the claim when billing residential room and board services, the total number of units reported in Value Codes 80 and 81 and the number of units billed in the claim service lines must equal the number of days in the statement from and through period.
- If a Discharge Status Code reported on the claim is not 20 or 30 when billing residential room and board services, the total number of units reported in Value Codes 80 and 81 and the total number of units billed in the claim service lines must equal one day less than the number of days in the statement from and through period. Illinois Medicaid only pays for the date of discharge if due to death (Discharge Status Code 20).

Common Billing Issues

- The total number of LOA days must be included in the Value Code 81.
- The service lines of the claim must also report the LOA days using the applicable Revenue Code 018X.
- If the claim has more than one service line with Revenue Code 018X then more than one Occurrence Span 74 must be reported.
- The total days reported as Revenue Codes 018X must balance with the total days reported in the Occurrence Span(s) 74.
- Please note that LOA begin and end dates are calculated differently based on what type of LOA is being reported.

- A therapeutic LOA begins the day after the resident leaves the facility and ends the day before the resident returns. For example, if the resident left the facility 3/2/17 and returned 3/5/17 the therapeutic LOA would be reported as 3/3/17 through 3/4/17.
- A hospital LOA begins the day the resident leaves the facility and ends the day before the resident returns. For example, if the resident left the facility 3/2/17 and returned 3/5/17 the hospital LOA would be reported as 3/2/17 through 3/4/17.
- When billing Developmental Training Services (DT) the total number of units reported in Value Codes 80 must equal the number of days in the statement from and through period regardless of the discharge status code reported. The number of units reported in the claims service line for Revenue Code 0942 should be the number of days the resident attended the DT program.

Common Billing Issues

- Providers billing for Developmental Training services (category of service 82 or 83) must use value code 24 to report the day training agency code.
- LTC facilities (Excluding Supportive Living Program PT 028) should not submit claims for service periods that a resident is receiving hospice care. The Hospice provider must submit claims for the service period that they are treating the resident.
- All diagnosis codes submitted must be a valid ICD-10 diagnosis code and be gender and age appropriate for the recipient.
- After submission of claims to the department it is strongly recommended that providers follow up by checking the status of claims via the 'Claim Status Inquiry' function in MEDI.
- A listing of error codes and their explanations can be found at www.illinois.gov/hfs/medicalproviders/handbooks under 'Additional Resources for Providers'. If you need assistance determining the reason for claim rejections please contact the Bureau of Long Term Care at (217) 782-0545 or (844) 528-8444 toll free.

HFS Bureau of Long Term Care Contact Information:

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