Institutional System Errors
For Hospital, Hospice, ASTC, and Birth Center Claims

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HFS System Issue	Providers Impacted	Problem Begin Date	Problem Fix Date
Error Code R17 Some claims are rejecting incorrectly for customers over the age of 21.	FSP Program Residential Treatment	Unknown	
Error Code A48 The system is not reading HFS Social Services eligibility correctly, which is causing claims to reject.	FSP Program Residential Treatment	02/03/23	
Error Code A48 The system is not reading HFS Social Services eligibility correctly which is causing all claims for Category of Service 021 for youth under the age of 22 to go on CH hold status.	Hospitals	02/03/23	The Department will review claims affected by the issue for HFS Social Services eligibility and adjudicate the claim accordingly. There is no action is required by Providers at this time. The issue does not affect timely filing. Providers should continue to submit claims for services provided to this population within the timely filing deadline to avoid rejection.
Error Code R03 The system is not reading eligibility information correctly for special eligibility segments. When claims are received, the system does not identify the customer as eligible and is inaccurately rejecting the claim. Eligibility on MEDI is correct.	Hospitals	Approximately 01/01/23	

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Error Code R15 Some claims are rejecting incorrectly for claims with dates of service prior to the date of death.	Hospitals	Unknown	
Some claims are stuck in “CC” status. HFS is reviewing the claims for a method of resolution.	Hospitals	Unknown	
Some claims are being reduced by an incorrect amount for the patient credit when there are two hospice segments in the same month for the customer.	Hospice	03/23/22	11/14/22 Providers must void and rebill the affected claims. HFS Form 2249 to void claims must be submitted within 12 months from the original paid voucher date per Chapter 100, 112.4. Resubmissions of the claim must be received within 90 days from the voucher date of the void. Exception: Claims that exceed the 12 month void rule prior to 6/26/23 can be reviewed by a consultant by contacting 877-782-5565.
Claims with DCN dates beginning with 2022180 and 2022181 rejected in error for C30, E70, E71, & M51.	All Institutional Providers	06/29/22 & 6/30/22	07/01/22 The issue has been resolved and claims will be systematically resubmitted by HFS. No action is required by the provider. A new DCN will be assigned and will be represented by a “6” in the 10th digit of the DCN. Example; 2022180906**6**00001.
Error Code U38 –Hospice/LTC Revenue Code Invalid for Recipient. Claims are rejecting when billing for admission or discharge date for customers who have been discharged from one Long Term Care facility and admitted to another Long Term Care facility.	Hospice	03/23/22	

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Error Code W79 – Missing Coinsurance/Deductible Inpatient claims showing Medicare Primary with TPL Code 909 and Status Codes 02,03,05 or 06 for which there is not a coinsurance or deductible are rejecting incorrectly.	Hospitals	12/14/21	9/15/22 Providers should rebill affected claims. Claims that are past the 180 day timely filing limit due to the issue must be billed with an HFS 1624A UB-04 Override Request Form requesting the G55 override. **The Department must receive the rebilled claims within 180 days from the system resolution notification date of 10/31/22.**
Error Code R10 – Service Not Covered for Recipient Category Inpatient and outpatient claims for customers who have *RENAL DIALYSIS ONLY* eligibility and *PRESUMPTIVE* eligibility on the same date of service are rejecting incorrectly.	Hospitals	09/01/20	02/03/23 Providers should rebill affected claims. Claims that are past the 180-day timely filing limit due to the issue must be billed with an HFS 1624A UB-04 Override Request Form requesting the G55 override. **The Department must receive the rebilled claims within 180 days from the system resolution notification date of 02/07/23.**
Claims rejected for A38, E33 and M33 for 2/25/22 (2056 DCN dates.)	Hospitals	02/25/22	Providers should rebill affected claims. Claims that are past the 180 day timely filing limit due to the issue must be billed with an HFS 1624A UB-04 Override Request Form requesting the G55 override. **The Department must receive the rebilled claims within 180 days from the system resolution notification date of 3/24/22.**
Claims requiring an admission review were being denied by our QIO organization, Kepro (eQ Health), due to an eligibility issue on non-citizen emergency customers. The issue affected both admission reviews through the QIO portal and those submitted to HFS for a retro-prepay review. Claims submitted to	Hospitals	07/09/21	Claims on hold for review will be rejected for C88. Providers should rebill affected claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) & A88 overrides. **The Department must receive the rebilled claims within 180 days from the system resolution notification date of 3/25/22.**

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HFS for a retro-prepay review have been on hold and did not transmit to EQ for the review.			
Error Code O39 - Recipient in an MCO Claims are being rejected in error because the HFS system identifies the customer in an MCO although MEDI identifies the customer as having regular HFS eligibility.	Hospital and ASTCs	03/01/22	10/11/22 Providers should rebill affected claims. Claims that are past the 180 day timely filing limit due to the issue must be billed with an HFS 1624A UB-04 Override Request Form requesting the G55 override. **The Department must receive the rebilled claims within 180 days from the system resolution notification date of 12/28/22.**
Hospice claims billed using revenue code 0651 are pricing double the daily rate for days 61 and over . This only affects claims that are reimbursable at two different base rates.	Hospice	02/28/22	Once the issue is resolved, adjustments will be processed for the recoupment of the overpayments.
The patient credit is being deducted from the wrong provider when a customer is inpatient in two facilities in the same month.	Hospice	11/16/21	03/23/22 Providers must void and rebill the affected claims. HFS Form 2249 to void claims must be submitted within 12 months from the original paid voucher date per Chapter 100, 112.4.1, Exceptions to 180-Day Time Limit. Resubmissions of the claim must be received within 90 days from the voucher date of the void.
The patient credit is being deducted from both claims in the same month when there are two hospice segments in the same month for a customer.	Hospice	11/16/21	03/23/22 Providers must void and rebill the affected claims. HFS Form 2249 to void claims must be submitted within 12 months from the original paid voucher date per Chapter 100, 112.4.1, Exceptions to 180-Day Time Limit. Resubmissions of the claim must be received within 90 days from the voucher date of the void.

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Error Code R03, Recipient Not Eligible on Date of Service The system is not reading eligibility information correctly for **some** non-citizen customers. When claims are received, the system does not identify the customer as eligible and is inaccurately denying the claim. Eligibility on MEDI is correct.	Hospitals and Hospice	11/23/21	The 6i and 7i eligibility issue has been corrected as of 2/8/22. Providers should rebill claims. Claims beyond 180 days from the date of service require G55 (timely filing) overrides by billing consultants. Providers should rebill claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code R10 - Service Not Covered for Recipient Category Inpatient and outpatient claims for customers who have *RENAL DIALYSIS ONLY* eligibility and *MEDICAID ELIGIBLE, FULL COVERAGE* eligibility on the same date of service are rejecting incorrectly.	Hospitals	9/1/20	03/16/22 Providers should rebill claims. Claims beyond 180 days from the date of service require G55 (timely filing) overrides by billing consultants. Providers should rebill claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code R03 – Recipient Not Eligible on Date of Service The system is not reading eligibility information correctly for non-citizen customers. When claims are received, the system does not identify the customer as eligible and is inaccurately denying the claim. Eligibility on MEDI is correct.	Hospitals and Hospice	9/1/2020 begin date of eligibility.	07/07/2021 Providers should rebill claims. Claims beyond 180 days from the date of service require G55 (timely filing) overrides by billing consultants. Providers should rebill claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code H30 – Missing/Invalid Amount for Covered Days (Related to the E84 Edit)	Hospitals	12/21/16	03/24/17 Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override.

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Problem: Edit currently failing to set on the paper claims where the Value Codes Amount (FL 39-41) is present, but not being picked up by the scanner and is reading as blank.			The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code E84 – Incorrect Covered Days (Related to the H30 Edit) Problem: Edit currently failing to set on the paper claims where the Value Codes Amount (FL 39-41) is present, but not being picked up by the scanner and is reading as blank.	Hospitals	10/28/16	03/24/17 Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code C68 – Illogical Patient Status Problem: Even if the Patient Status (FL17) is correct, the claim is still rejecting.	All Institutional Providers	10/01/16	03/24/17 Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code – C88 – Prepayment Review Problem: Claims are rejecting even before they go to eQHealth.	Hospitals	01/01/16	TBD Resolution: In the interim, providers should rebill the claim with an HFS 1624A UB-04 Override Request Form requesting the A88 override, which will allow the claim to suspend again for review by eQHealth.
Error Code X41 – Prepay Review Problem: When eQHealth sends the return file to HFS indicating whether the claim has been approved or denied, the system should automatically update and release the claim from a hold status, but this is not occurring.	Hospitals	01/01/16	TBD Resolution: In the interim, if eQ Health has completed the review, the provider should rebill with the appropriate documentation to an HFS billing consultant with the HFS 1624A Override Request Form indicating an X41 (and G55 if necessary) override is needed.

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No Specific Error Code Problem: HFS currently cannot price claims with a date range over 365 days through the processing system.	Hospitals Billing Claims with a Date Range over 365 Days	07/01/14	TBD Resolution: In the interim, these claims must be billed on a UB-04 and sent to a billing consultant at: Illinois Department of Healthcare and Family Services, P.O Box 19128, Springfield, IL 62794-9128. Currently, claims are being priced and paid by a C13 payment voucher.
Error Code X75 – Missing HCPCS Code for Observation Problem: All outpatient claims rejected even if they were not observation claims.	Hospitals	12/23/16	01/03/17 Resolution: HFS sent a listserv to providers regarding this problem. It affects claims with DCN dates within the dates range listed above. Providers should be rebilling electronically if possible.
Error Code A39 - APL HCPCS Code Required on Outpatient Claim. Problem: Although outpatient claims are no longer paid based on the highest-paying APL code, claims still require an APL code on each date of service with the exception of ER/Observation which may span more than one day and is considered one episode of care. The system error contains several components including rejecting a claim when the ER or Observation is coded correctly. Also, the HCPCS codes are not scanning correctly; therefore the system cannot read the code as valid. In addition, MMIS (Department's system) is not looking at the code's history.	Hospitals and ASTCs	01/01/16	01/01/17 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code K02– ECI Code not from ICD-10	Hospitals	10/01/15	12/27/16

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Problem: System not editing correctly on the ICD-10 External Cause Codes.			Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code K03– Diagnosis Not from ICD-10 Error Code K06 – ICD Indicator/Code Invalid for Date Error Code – K10 – Admitting Diagnosis not from ICD-10 Problem: System not editing correctly on the ICD-10 coding.	Hospitals	10/01/15	12/27/16 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code D06 – Procedure Date Outside Per Diem Range Problem: The D06 is occurring erroneously in **some** instances. HFS does not follow Medicare's 72-hour "bundling" rule; therefore, any inpatient claims submitted cannot have a procedure prior to admission.	Hospitals	10/01/15	11/24/16 Resolution: The consultants are able to override the G55 error **as long as the procedure code is not prior to or after the From and Through dates on the claim.** Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code U31 – Series Billable Revenue Code Required Problem: Non-series claims such as ER and hospice were rejecting.	Hospitals, ASTCs, and Hospices	05/01/16	10/31/16 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code P59 – Care Not Appropriate for Children's Hospital	Children's hospitals	11/01/15	10/12/16 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing)

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Problem: Erroneous rejections are occurring as a result of incorrect language in the edit. The edit currently looks at all diagnosis codes instead of just the principle diagnosis.			override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code R90 – Diagnosis Inappropriate for Hysterectomy Problem: Claims were rejecting for missing hysterectomy diagnosis even though a diagnosis was on the claim.	Hospitals and ASTCs	01/01/16	10/05/16 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code C19 - Missing or Invalid Sterilization/Hysterectomy Form Problem: 28 procedures were coded as sterilization procedures in error. Procedures beginning with alpha letters OUL ending in 5OZZ, 53CZ, 53DZ, 54ZZ, 60ZZ, OUT ending in OOZZ, O4ZZ, 07ZZ, 08ZZ, OFZZ, 10ZZ, 14ZZ, 17ZZ, 18Z2, 50ZZ, 54ZZ, 57ZZ, 58ZZ, 5FZZ, 60ZZ, 64ZZ, 67ZZ, 68ZZ and 6FZZ were affected.	Hospitals and ASTCs	01/01/16	08/09/16 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date. *Please note – if a provider receives the C19 error code and it does not include one of the codes listed in the system issue, the sterilization/hysterectomy form may be incomplete. Please review the form to determine all the necessary information was completed.
Error Code U92 – Provider Not Authorized for DCFS Screening Problem: The edit was not setting correctly and caused the claims to reject in error.	Hospital and ASTC	10/19/15	07/28/16 Resolution: This was an old error prior to Rate Reform in July of 2014. Since all outpatient claims now go through the EAPG grouper, the edit no longer applies to any claims and was made obsolete on 07/26/16. Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code U29 – Outpatient Claims Cannot Contain More than 1 APL Group	Hospitals and ASTCs	05/01/16	07/26/16

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Problem: Claims cannot have multiple APL Codes from different groups on one claim.			Resolution: This was an old error prior to Rate Reform in July of 2014. Since all outpatient claims now go through the EAPG grouper, the edit no longer applies to any claims and was made obsolete on 07/26/16. Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.
Error Code C16 – Procedure Not Covered By Medicaid In error, ICD-10 Codes 3EOP7GC and OUQ00ZZ were coded as non-covered. 45388, 45390, 45393 and 45398 were coded incorrectly on MMIS.	Hospitals and ASTCs	10/01/15	05/16/16 Resolution: Providers should rebill the claims with an HFS 1624A UB-04 Override Request Form requesting the G55 (timely filing) override. The Department must receive the rebilled claims within 180 days from the system resolution date.