CHAPTER 5 – Error Resolution

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This chapter provides information and reference materials routinely needed by IL Medicaid managed care organizations (MCOs) in resolving errors related to failed encounters so that encounters may be successfully resubmitted. Commonly asked questions by MCOs are answered and presented below under their respective file type: Institutional, Professional and NCPDP. Supplemental information is provided to augment the primary IL Medicaid error/rejection documentation. Finally, a link is provided to comprehensive error resolution documentation created by MCOs through the IL Medicaid Submission Improvement Workgroup.

1. Institutional Claims – Q&A

1. Will HFS accept interim claims?

A Yes, HFS accepts interim encounter data claims for per diem stays.

2. How to submit inpatient encounter when the member became eligible in the middle of the stay?

A Refer to Section 260.11 of the Handbook for Hospital Services for specific instructions:
http://www.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf

3. What are the parameters for length of stay when submitting an interim claim?

A Refer to Section 260.21 of the Handbook for Hospital Services for guidelines related to submitting interim claims.

4. What are the business rules for accepting Frequency Code 5?

A HFS accepts Bill Frequency 5 for late ancillary charges. These encounters pay at zero.

5. Are Home Health services submitted via 837I or 837P?

A Home Health services must be submitted via 837I.

6. What is the process for institutional claims with an amount in excess of $9,999,999.99?

A For inpatient claim that are paid through DRG, the claim cannot be split. DRG claims are to be billed admit through discharge. For per-diem claims (i.e. psychiatric or rehab), the claim could be split. For general inpatient, it would depend on the length of stay. Additional guidance will be provided as these cases arise.

7. How are home health claims returned on the remittance advice file?

A While home health claims are submitted on the 837I, they are returned as NIPS (Non- Institutional Professional) claims on the remittance advice file.

8. How to report covered and non-covered days?

A Follow below instructions to report covered and non-covered days correctly for Inpatient, Outpatient and Hospice claims.

A On the claim level, report total length of stay which is service from to service thru.
DTP*434*RD8*20140710-20140719

B Number of days of stay does not include day of discharge (DOS Thru Date – DOS From Date) for Bill frequency type code 1 and 4.

Patient discharged status code is not expired.

C Report non covered dates on HI*BI segment with occurrence span code 74

HI*BI:74:RD8:20140715-20140718

D Report covered and non-covered days on HI*BE segment with value code 80 for covered days and 81 for non-covered days

HI*BE:80:::5*BE:81:::4*BE:01:::19.29

http://www.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf

E On service lines level, Units reported with accommodation revenue codes must be equal to total number of covered days

SV2*0120**9645*DA*4

DTP*472*RD8*20140710-20140719

LX*2

SV2*0202**4245*DA*1

DTP*472*RD8*20140710-20140719

F **Hospice and LTC claims only**: For following patient status codes include day of discharge for covered non covered day calculations. (DOS Thru Date – DOS From Date)+1

20 Expired.

21 Expired-Not covered by Medicaid on date of death

22 Expired to be defined at HFS level

23 Expired to be defined at HFS level

24 Expired to be defined at HFS level

25 Expired to be defined at HFS level

26 Expired to be defined at HFS level

27 Expired to be defined at HFS level

28 Expired to be defined at HFS level

29 Expired to be defined at HFS level

40 Expired at home.

41 Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice).

42 Expired - place unknown

G Patient status 30- Mostly billed for interim claims.

- If Bill frequency type code (On CLM Segment) is 1 or 4 – Do not calculate day of discharge in covered-non covered day calculations

- If Bill frequency type code is 2 or 3 – Include day of discharge in covered-non covered day calculations.
- Please find description below.

  Admit through Discharge Claim = (DOS Thru Date – DOS From Date)

  Interim-First Claim = (DOS Thru Date – DOS From Date)+1

  Interim - Continuing Claim = (DOS Thru Date – DOS From Date)+1

  Interim-Last Claim= (DOS Thru Date – DOS From Date)

9. How to report Admission date?

A Admission cannot be greater than HFSment from date except for interim claim.

10. How to report APL groups on series bill claims?

A Multiple HAR groups cannot be billed on same series bill claim. Please find instruction on series bill claim below on page 89.

http://www.illinois.gov/hfs/SiteCollectionDocuments/h200_archived.pdf

Please find APL group description below.

GROUP 1. Surgical

a. Surgical – Intensive

b. Surgical – Moderate

c. Surgical – Low

d. Surgical - Very Low

GROUP 2. DIAGNOSTIC AND THERAPEUTIC

a. Complex Diagnostic and Therapeutic

b. High-tech Diagnostic

c. Other Diagnostic

d. Therapeutic Procedures

GROUP 3. EMERGENCY ROOM PROCEDURES

a. Emergency Level I

b. Emergency Level II

c. Non-emergency/Screening

GROUP 4. OBSERVATION SERVICES

a. 1 hour through 6 hours, 30 minutes

b. 6 hours, 31 minutes through 12 hours 30 minutes

c. 12 hours, 31 minutes or more

GROUP 5. PSYCHIATRIC SERVICES

a. Type A

Children's hospitals as defined in 89 Illinois

Administrative Code 149.50(c)(3)(A)

b. Type B

Children's hospitals as defined in 89 Illinois

Administrative Code 149.50(c)(3)(A)

11. How to report POA Indicator?

A All Inpatient claims require POA indicator on primary and all secondary diagnosis codes.

Refer to below link for reporting guidelines.

http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn080312a.aspx

12. How to report APL codes on outpatient claim?

A All outpatient claims must be submitted with at least one APL HCPCS code. If these claims are truly APL, the provider would then either have to bill HCPCS code(s) that are on the APL list or change this claim from 837 Institutional to 837 Professional. If any outpatient claim submitted to HFS without APL HCPCS code, it will be rejected with A39 error code.

APL listing can be found on link below

http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/AmbulatoryProceduresListing.aspx

13. How to report admin denial codes?

A Any admin denial code must be reported with condition code '04'. Condition code '04' can be reported at header level in loop 2300.

2. Professional Claims – Q&A

1. How are zero paid service lines to be reported?

A If a claim or service line is paid at zero, submission of the encounter data is required and the HCP01 value is required to be '14' with zero dollars reported in HCP02

2. When is NDC code required to be submitted on a claim?

A HFS publishes the practitioner's Fee Schedule periodically. The NDC code is required for all the codes on the fee schedule when Drug indicator = 'Y'. The HFS Practitioners Fee Schedule is published below

http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/Pages/default.aspx

3. Which provider types are allowed to bill the encounter rate (T1015) procedure code?

A T015 can only be billed by Federally Qualified Health Centers (FQHCs – Provider Type 040), Encounter Rate Clinics (ERCs – Provider Type 43), and Rural Health Clinics (RHCs – Provider Type 048).

4. For FQHC, RHC, and ERC encounter data claims, should the T1015 procedure code always be reported as the first service line?

A Yes, T1015 should always be reported as the first service line for these claims.

5. Should the Billed Amount for FQHCs, RHCs, and ERCs be populated based on the rate published on the HFS website for the appropriate year?

A It is not necessary to populate the Billed Amount with the HFS rate from the website. It is acceptable to send the provider charge amount in the Billed Amount for the T1015 service line as long as the amount is greater than zero. The service line will be priced according to HFS' contractual agreement with the provider, even if that amount is more than the provider charge amount.

6. When billing the T1015, will the encounter data claim reject if an Evaluation and Management (E&M) procedure code is not present to denote a face-to-face visit?

A No, an E&M procedure code is not required to be submitted with the T1015.

7. When an all-inclusive procedure code is billed (i.e. T1015 for FQHCs), how should the detail lines be sent if the procedure was paid at zero?

A All service lines, including those paid at zero, are required to be submitted. For zero paid service lines, the HCP01 value is '14' with zero dollars reported in HCP02.

8. For capitated transportation providers, are the encounter data claims to be submitted as paid at zero?

A These capitated encounters should be priced per the HFS fee schedule rather than submitted as paid at zero.

9. For capitated transportation providers, is the NTE segment containing specific trip information required?

A Yes, the NTE segment must be submitted as described in the HFS 837P Companion Guide: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

10. HFS requires the license plate number to be submitted for transportation claims, can the VIN be submitted instead of the license plate number?

A No, per the Office of Inspector General (OIG), the license plate number must be submitted.

11. For transportation claims, vehicle license number and the HFS where licensed was issues are not HIPAA-required values. Can this requirement be relaxed for encounter data?

A This requirement applies to all transportation providers billing HFS fee-for-service and cannot be relaxed for encounter data claims.

12. With regard to void/rebills for professional claims, is the claim replaced or is just the line replaced?

A A void/rebill transaction can be submitted for professional encounter data at either the claim level or the line level. Specific instructions are available in the HFS 837P Companion Guide: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx.

13. How to report 837- administrative denials (HCP04) Element?

A D0 – Timely Filing
D1 – Authorization
D2 – Pre-Certification
D3 – Benefit/Covered Service
D4 – Medical Necessity
D5 – Provider
D6 – Additional Information

14. How to resolve error code D01 – Duplicate Payment Voucher generated?

A Refer to MCO billing guidelines presentation on Provider Memo.
http://iamhp.net/billing-guidance

15. How to create FQHC encounters.

1. For Rural health clinics (provider type 048), encounter rate clinics (PT 043) and federally qualified health centers (PT 040), Provider should always submit their claim with first service line billed with Code T1015.

This service line will be paid as per HFS pricing system. HFS will reject any claims for this provider type if the first service Line is not billed with code T1015.

2. For PT 043 and 048 and 040, they can also submit the claim with service line billed with code S5190 (wellness Assessment performed by no physician). This service line will be paid 00.00 as it is to collect correct data on Immunization or other services not provided by the physician.

3. The claim cannot be submitted with both these codes T1015 and S5190 at same time.

4. To submit dental claims above mentioned provider types should be registered for category of service 002. The dental claim must be reported with Procedure code 'D0999' on first service line on the claim. This service line will be paid as per HFS pricing system. HFS will reject any claims for this provider type if the first service Line is not billed with code D0999.

5. For DOS greater than 07/01/2014 Claims must be submitted with the NDC for each J code on the Claim.

http://www2.illinois.gov/hfs/SiteCollectionDocuments/092414_FQHC_presentation.pdf

16. How to submit an encounter when provider is billing for professional services while patient is at the hospital?

1. All Providers need to be registered with HFS to get Illinois Medicaid ID. If provider is not registered with HFS, claim will be rejected.
2. HFS requires that outpatient encounters submitted via an 837I include one of the following:
   - Ambulatory Procedure Listing (APL) procedure code
   - Emergency room revenue code
   - Operating room revenue code
3. In all cases where one of these three criteria is not met, MCOs must submit the encounters to HFS via an 837P. The MMIS will reject these types of encounters if this protocol is not followed.

17. How does HFS split professional claims?

A HFS adjudication system generates a unique Document Control Number (DCN) for each accepted 837 claim. HFS system may split the claim and assign more than one DCN to one Claim (Claim ID/Patient Control Number – Submitted on CLM*02).

A The HFS system generates a new DCN for each ten service lines submitted on a claim. E.g. if the original claim (claim ID: HFS000999) is submitted with 15 service lines, the HFS system will generate two DCNs for the claim ID HFS000999.

B When HFS System split the claim and assigns more than one DCN for one claim, it will always assign DCNs in subsequent increasing numbers. E.g. DCN # 5678901, 5678902, 5678903 for claim ID HFS000999.

C If the claim splits into multiple DCNs, each DCN generated for the original claim will have same Patient control Number.

D MCOs must wait for the final result of the original encounter from HFS in the form of a remit, before initiating any kind of void/rebill, reversal, adjustment/replacement request for the same encounter claim. MCO must void each DCN for MCO Claim ID before resubmitting corrected encounter.

18. How to resolve error code D08 - claim receipt prior to billing/ service date?

A The claim bill date in BHT04 segment should always be greater than the latest service date reported on file.

19. How to resolve error code G41 - Missing MCO payment to provider?

A Error G41 will occur if

- HCP line segment is not sent in the claim OR
- HCP01="00" and HCP02 is not zero OR
- HCP02 is blank OR
- HCP01 is not "00" and HCP02=zero.

20. How to report Evaluation/Management (E/M) visit on the same day as LARC insertion or removal (How to resolve error code G70)?

A Providers should submit two separate claims to HFS : 1- For device as FFS claim submit directly to HFS. 2- Encounter claim for the services provided submit to MCOs. Please find more information on link below

http://www.hfs.illinois.gov/html/101014n1.html

21. What are all the modifiers HFS accepts?

A HFS accepted modifiers published on link below.

http://www.illinois.gov/hfs/SiteCollectionDocuments/082112modifier.pdf

22. What modifiers does HFS accept for anesthesia?

A HFS accepts only physical status anesthesia modifiers from P1 thru P6.

23. How to resolve error C97?

A C97 error will occur on a claim, if a claim is submitted with any of the following

A T1015 is not billed on the claim by an FQHC
B T1015 is billed on the claim by an FQHC with ancillary services/visits paid at $0.
C T1015 is the only service on the claim billed by an FQHC, without any payable ancillary/service visit codes. Additional information can be found here from page 21 –

http://www.illinois.gov/hfs/SiteCollectionDocuments/FQHCPresentation09242014.pdf

24. What causes a G46 error?

A If the claim received date is missing on K3 segment, it will result in G06 error. The K3 segment with claim received date and claim paid date is required for both 837P and 837I.

25. What causes an A46 error?

A If the claim paid date is missing on K3 segment, it will result in an A46 error. K3 segment with the claim received date and the claim paid date is required for both 837P and 837I.

26. What are the guidelines for submitting an inpatient encounter claim when the member became eligible in the middle of the stay?

A Refer to Section 260.11 of the Handbook for Hospital Services for specific instructions:

http://www.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf

27. What causes a W61 error?

A If recipient is not enrolled with the MCO on the date of service which has been reported on the claim, it will result in the W61 error. Check the recipient eligibility on the 834 files that HFS sends out to all MCOs.

28. What causes diagnosis code related errors for dental files?

A Diagnosis code related errors (N01, M36) appear on dental files for following reasons:

- A Provider is not registered as a dentist. (Provider type 011)
- B Provider is not registered for dental services (COS 002)
- C Taxonomy code is not for a dentist provider.
- D FQHC providers are billing without D0999 on the first service line.

29. What causes A40- Invalid voids or void/rebill transaction error?

A A40 error will result for the following reasons:

- A If MCOs are trying to void claims which were never submitted to HFS.
- B If MCOs are trying to void claims which were rejected in initial submissions.
- C If MCOs are trying to void claims which they have not yet received back on a remit file.
- D If MCOs are submitting void requests with wrong bill type frequency code.
- E If MCOs are trying to void claims that have already been voided.

30. IS NPI required for atypical providers?

HFS does not require atypical providers to have NPI. Atypical providers have to submit claims with only their HFS Medicaid ID.

3. NCPDP – Q&A

1. Is there a HFS–specific pharmacy encounter data format in order for the HFS to obtain rebates?

A Pharmacy encounters must be submitted via NCPDP 1.2 batch transaction.

2. What are the expected values for the Processor control number (104-A4) and vendor ID/Certification ID (110-AK)?

A HFS does not edit on the information in these fields. Note that the processor control Number (104-A4) cannot be left blank.

3. What information should be sent in the sender ID?

A Each MCO plan is assigned a unique Sender ID. This must be submitted in the transaction header record.

4. Is there a limit to the number of records that can be submitted in an NCPDP 1.2 batch File?

A Due to the assignment of unique transaction control numbers, no more than 499,999 records can be processed in a day. Files exceeding this record count will be rejected and will need to be resent in smaller increments. The total records received and processed from all MCOs in a day cannot exceed 499,999. Once the maximum number of claims has been processed, any pending files will be held and every attempt made to process the following day. We strictly recommend submitting a maximum of 20,000 pharmacy records on a given day.

5. When will the NCPDP response file be available?

A NCPDP batch files will be processed seven days a week. Response files should be available immediately available after file is submitted, unless the volume threshold described in Answer 6 is met. In the event the volume threshold has been met every attempt will be made to process files the next day.

6. What information will be returned on the remittance advice file to tie the claim back to the original submission?

A HFS will return the Prescription Number (field 402-D2) in the PROV-REF-NUM-GRP Field on the remittance advice file. While the prescription Number may not be unique, it can be used in combination with other fields to tie back to the original claim submitted.

7. What criteria will cause a claim to "dupe" out in the system?

A Duplicate Claim criteria require a match on all 5 data elements below:

1. 401-D1 Date of Service
2. 201-B1 Service Provider ID
3. 402-D2 Prescription Reference Number
4. 302-C2 Cardholder ID
5. 407-D7 Product ID

8. What is the timing of updates to the Valid NDC listing?

A NDCs are validated against MediSpan and updated every week.

9. How often is the labeler list on the website updated?

A It is updated every quarter, on the first week of the second month following the previous quarter. For the Jan'18 thru March'18 quarter, the updates will happen towards the end of the first week of May'18.

Background info - Each quarter, prior to our invoicing cycle, Federal CMS provides HFS with a Labeler File that contains information on all labelers that have a valid rebate agreement that allows them to participate in the Drug Rebate Program.

10. What is the value for the field 407-D7: Product/Service ID should be used when submitting the Drug compound?

A 407-D7: Product/Service ID needs to be populated with one zero or eleven zeros.

11. In the case of over the counter emergency contraceptive drugs (e.g. Plan B, etc.), that do not require a prescription and there is not a prescriber attached to the claim, does the HFS have a dummy prescriber NPI?

A Dummy prescriber NPI – 2223334444 should be used.

12. What are DUR/PPS fields?

A 15 DUR/PPS fields are located in the AM08 segment which is a situational segment. It is just data we store on the raw data database. Whether the fields are sent or not will not impact whether the claim is payable or not.

13. What kind of data would be in the DUR/PPS fields located in the AM08 segment?

A The DUR/PPS fields are used for retrospective Drug Utilization Review to indicate a reason for the need for an intervention on a prescription, the professional service that the pharmacy performed and the result of that professional service. Currently the below given fields are not required fields and when the fields are sent on a claim, the HFS is only storing the information. The pharmacy will use one of the Professional service codes to indicate when the pharmacist administered a vaccine injection along with billing HFS for the vaccine itself.

- Incentive Amount Submitted (438-E3)

- Professional Service Code (44Ø-E5) = MA.

14. What are the Units of Measure for NCPDP that HFS accepts?

A F2 (international unit)

- GR (gram)

- ML (milliliter)

- UN (unit)

15. What is the correct transfer for the NCPD file?

A For NCPDP file, the command must be xlate=althipaa

Correct transfer (HEX ON) –

1E – Segment separator

1C – Field separator

Incorrect transfer (HEX ON) –

35 and 22 are invalid values

16. For the NCPDP response file, what should be the criteria for the Prior Authorization Type Code and Prior Authorization Number?

A Here is an example of how these 2 field values should be submitted. The field definition applies to all the fields submitted on the request; otherwise such records will fail the translator validation.

Auth#(11 byte)	**Code (2 byte)**
52593450863	01
00000004602	01
16183550881	08
10000070411	02
00099381456	00

Please note that both fields are numeric (therefore characters are not allowed) as per the guide and are situational. Below are the PA type code definitions.

Code	**Description**

00 Not Specified

01 Prior Authorization

02 Medical Certification

03 EPSDT (Early Periodic Screening Diagnosis Treatment)

04 Exemption from Copay and/or Coinsurance

05 Exemption from RX

06 Family Planning Indicator

07 TANF (Temporary Assistance for Needy Families)

08 Payer Defined Exemption

09 Emergency Preparedness

17. What provider specialties are allowed by HFS to prescribe medications?

A A. If other provider types become eligible to prescribe based on HFS law that would be enrolled as prescribers as well.

1. Physicians
2. Dentists
3. Optometrists
4. Podiatrists
5. Nurse Practitioners
6. Physician's Assistant

4. Edit Error Resolution

This section augments Error Codes (xls), which is the most current listing of HFS error codes and descriptions (the Error Codes spreadsheet is maintained on URL website https://www.illinois.gov/hfs/SiteCollectionDocuments). It is recommended that the reader use the *Ctrl-F* function to search for specific error codes when using this section.

1. A51 Service Allowed For FQHC/ERC/RHC Only

- FQHC (PT 040), ERC (PT 43) and RHC (PT 48) required T1015 procedure code on first service line of each claim.
- Any other provider billing T1015 procedure code on first service line will be rejected with A51.

2. C31- Procedure not on file for date /C32 - Procedure Illogical for Category of Service

- Many C31/C32 issue has been addressed with our Cycling claim resolution. MCOs will receive C31/C32 rejections for the following scenarios:

- If provider is billing services not listed on respective fee schedule on date of service
- If provider is billing services he/she is not registered to bill on date of service
- If provider is billing with wrong taxonomy which will result in assigning wrong category of service on claim.

3. C97 - No payable services on claim

Following scenarios will result into C97 rejections

- If no T1015 code on first service line
- T1015 billed on first service line but missing detail services.
- T1015 billed on first service line with zero payment made with no detail services reported (HCP*14*0)
- Details billed on first service line with zero payment (HCP*14*0) or administratively denied (HCP*00**0*D7) with no encounter code reported on first service line.

4. C95- Procedure/ Service must be Billed on UB Invoice or 837I

- HFS rejects any services that hospital bills on 837P for procedure code for an APL service. Resubmit the claim on 837I.

5. D06 - Procedure Date outside Per Diem Range

- If procedure date on 'HI' segment is before or after HFSment from to HFSment thru date, claim will receive D06 error.

6. D91 - Psychiatric Care not approved as Billed

- Only Psych hospitals (PT 031 or COS 021) can bill psych principle diagnosis code for more than 3 covered days.
- All psych inpatient claims should be submitted with correct taxonomy code for psych hospital.

7. D09, E84, H07, H29, H34, U60 - Reporting Covered/Non-covered days

A . Refer to question 8 of Institutional Q&A.

8. E07 –Missing NDC

- HFS publishes Practitioner's fee schedule at http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx
- All procedure code with drug indicator ='Y' on practitioner's fee schedule will require NDC on the claim. NDC reported on claim should be 11 bytes.

9. E37 – Missing/Invalid Type of Admission

- If admission type code is missing on CL1*01 segment on 837I.
- HFS accepts admission type code only 1 thru 5, any other admission type code will be rejected with E37.

10. G37 - Missing/Invalid condition/admin denial code.

- Any administrative denial code must be reported with the condition code '04'.
- Condition code '04' can be reported at the header level in loop 2300. If the condition code is missing with the administrative denial code or administrative denial is missing with condition code present on claim, the claim will be rejected with the error code G37

11. H25 - POA Present on Admission Indicator Required.

- Present On Admission (POA) indicator (Y or N or U or W) is required on primary and all secondary diagnosis code of an inpatient claim.

HI*BK:4660:::::::**Y**~

HI*BF:0793:::::::**Y***BF:1120:::::::**N***BF:2449:::::::**Y**

12. H42 and P03 – BLACK HOLE/PROVIDER NOT ENROLLED FOR COS.

MCOs need to ensure that all the rendering providers received on the 837P and billing providers received on the 837I registered with a HFS with valid provider type, taxonomy, COS and payee account. There are some exceptions to that for FQHCs, ERCs, and RHCs where the billing provider needs to be registered. If the provider is not in the HFS file for the submitted encounters, then those will be rejected by HFS.

1. Providers can be retroactively enrolled upon registration with HFS, but some providers like transportation, DME are considered as high risk by OIG and they will not be retroactively enrolled. Therefore, encounters which are accepted by plans for such providers will be rejected until the date of service on the encounters is greater than or equal to enrollment date provided by OIG for such providers, once they are approved.

2. **P48** - Non-Participating Provider/Returned Mail Contract Department. Such providers will be identified with a status of 'N' - Active- Nonparticipating, have not had claim paid or rejected in previous 18 months. These providers will need to contact HFS PES and get their license and/or current address updated. Additionally, these providers need to register with payee, who is certified by PES, by submitting their W-9. Detailed requirements can be found on the HFS site.

   http://www2.illinois.gov/hfs/MedicalProvider/Enrollment/Pages/default.aspx

3. **Black hole providers** – Encounters that are rejected due to issues with provider information will be flagged with error status code of 'Y' (i.e. 128th position in the proprietary remit file) for each encounter

response back to the plans. Common errors are Medical/Dental - H42, P48, P05 and Pharmacy – H42 and P70. Explanation of these errors can be found here.

http://www2.illinois.gov/hfs/SiteCollectionDocuments/100app5.pdf

4. Elements that are used for matching/accepting encounters (NPI check)

    1. Rendering provider NPI against the crosswalk table.
    ** If no rendering is present then**
    2. Billing provider NPI match against the crosswalk table.
    3. When a one-to-one relationship between the HFS Provider ID and NPI does not exist, it is necessary to consider other fields in the NPI collection/ crosswalk database (HFS provider extract) to determine a 'unique' match. Therefore, a hierarchy has been established as follows:

Hospitals

1) NPI
2) NPI and Transaction Type code*
3) NPI and Taxonomy
4) NPI, Taxonomy and Transaction Type code*
5) NPI and Zip Code (5 Positions)
6) NPI and Zip + 4 (9 Positions)
7) NPI, Taxonomy and Zip Code (5 Positions)
8) NPI, Taxonomy and Zip + 4 (9 Positions)
9) No match, claim to Black Hole report

NIPS (Non-Institutional)

1) NPI to HFS Number
2) NPI and transaction type code*
3) NPI and 5 digit Zip Code to HFS number
4) NPI and 9 digit Zip Code to HFS number
5) No match, claim to Black Hole report

*Transaction Type Codes include – This is derived based on claim type.

N – Pharmacy
I – Institutional
P – Professional
D – Dental
W – Waiver

Note – Since the HFS provider extract file doesn't contain the taxonomy code and effective dates, it is expected from providers to bill with right taxonomy based on the dates of service on the claim, otherwise the tie-breaker logic above won't work and corresponding encounters will be flagged as black-hole (H42- NPI not useable). Taxonomy code has been added to the tie-breaker logic for NIPS as well.

5. 'Tie-breaker' data elements are not submitted on the NCPDP transaction. A one-to-one NPI to HFS Provider ID is expected.
6. Atypical Providers do not have to get NPI, but they have to be registered with HFS and obtain HFS Provider IDs to and that should be use instead of NPI. Emergency Transportation providers have to get NPI and use NPI to use for while submitting claims.
7. If the NPI is not registered with the Department, the claim will fall onto the "black hole report" or provider error file.
8. HFS will match against the first 20 bytes in the Provider Name looking for an exact match in the provider extract file. MCOs can refer to HFS file as part of audit before sending files to HFS.
9. Guidance on taxonomy (specialties) for submitting encounters.
    1. Once the provider record is identified through NPI check, the elements from X12 i.e. Provider taxonomy, bill type and provider type (from HFS file) is utilize to derive the provider category of service. This is to ensure that the provider is billing for the services for which it has been approved as part of enrollment process with PES.
    2. If a match isn't found - MCOs will receive P03 error, indicating that providers aren't registered for the category of service on the dates of services billed on the encounter.
    3. If the Plan submits claims with CRC*ZZ, HFS will assign COS 30- Healthy Mom Healthy Kids Service. Plans are encouraged not to submit CRC*ZZ Segment if not required.

Refer the Taxonomy code crosswalk for 837I and 837P under references section below link –

http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/5010.aspx

Note – HFS accepts all the taxonomy code published on CM/WPC site.

10. H-42 Checklist for Providers–

This list contains few checks that plans can perform upfront on their encounter creation/submission to HFS on all claims

1. If NPI on the claim isn't present on the Provider enrollment/extract file, reject/hold the claim until the providers gets registered with the HFS.

2. If the NPI on the claim is present on the Provider enrollment/extract file, but is in inactive status, then HOLD the claim until the provider gets activated after contacting our PES.

3. If the NPI on the claim is present on the Provider enrollment/extract file, but is active only after the DOS on the claim, then reject the claim back to the provider, as such claims will be rejected by HFS.

4. If the NPI on the claim is present on the Provider enrollment/extract file, but isn't enrolled for the COS, then HOLD the claim, until the Provider registered with the COS with our PES or bills with a different NPI, which is registered for the services billed on the claim.

5. If the NPI on the claim is present on the Provider enrollment/extract file, but there are multiple Medicaid IDs, then HFS assigns tie-breaker elements i.e. TransType, Taxonomy code, zip code.

13. M33 – MISSING COS OR BILL INDICATOR

- HFS requires the correct taxonomy code to assign right Category of service (COS).
- If there is a missing or invalid taxonomy code (A38) on claim it will result in A38, M33 and P98. Correct use of taxonomy codes will resolve all three errors.

14. M52 Observation Bed Charge Required

- Hospitals and ASTCs are required to code observation services with Revenue Code 0762 and an associated HCPCS Code as identified in the listing. (99218, 99219, 99234, 99235, and 99236), and note the number of hours in observation in FL 46 – Service Units.
- Additionally, providers must code a second Revenue Code 0762 line and identify HCPCS code G0378 in order for observation services to process correctly. The minimum billable observation time will be one hour.

15. M77 Missing/Invalid Vehicle License Number

- Vehicle license number should be reported on NTE02 segment in 2300 loop with HFS specific format.
- Guidance on correct representation of transportation claim is available on 837P companion guide in chapter 300.
  http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx Page 19
- Transportation provider handbook is available under chapter 200
  http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx

16. P60 -Care not appropriate for Adult hospital

- Detailed explanation of this error code can be found on General Appendix 5 – Error code explanations.
  http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx

17. P59 -Care not appropriate for Adult hospital

- Detail explanation of this error code can be found on General Appendix 5 – Error code explanations.
  http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx
- Additional provider notice was issued for P59 error code.

http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn141031a.aspx

18. U31 Series bill revenue code

- HFS publishes Series billable revenue code on Hospital appendices in Chapter 200. Series claims must contain at least one series billable Revenue Code. http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx
- HFS had some issue with U31 edit in the month of November 2015. The problem was discovered in early November and identified as starting around 10/30/2015. The hold was placed on the U31 error on 11/12/2015 and released on 11/18/2015. Claims that received the U31 error on DCN dates between 10/29 and 11/13 should be resubmitted.

19. U32 Procedure Not Valid For Series Bill

- Series bills must contain at least one APL procedure which has been approved for series bills.

5. MCO Billing Guidelines and Presentations

Since 2016, MCOs and members of the HFS Encounters Team meet weekly through the Illinois Medicaid Submission Improvement Workgroup to collectively address the most pressing challenges for MCOs related to encounter submission to HFS. The Workgroup would periodically stratify what MCOs assessed as the challenging errors and then MCOs worked together to create and approve memorandums and presentations which are presented on the Illinois Association of Medicaid Health Plans (IAMHP) website: http://iamhp.net/billing-guidance.