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'.

- 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.

- When submitting a claim to Medicare include the billing provider taxonomy code on the claim to assist in the crossover process to the department.

- Claims submitted Fee for Service to the Department must have an LTC admission segment on the system at the time of submission for all dates included in the service period of the claim. The LTC admission segment can be viewed by performing an LTC Inquiry via the MEDI System.

- 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 <u>prior</u> 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 <u>not</u> 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 <u>one day</u> 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).

- Claims reporting leave of absence days (LOA) must indicate the LOA periods using Occurrence Span Code 74.
    - 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 3/2/21 and returned 3/5/21 the therapeutic LOA would be reported as 3/3/21 through 3/4/21.
        - 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 3/2/21 and returned 3/5/21 the hospital LOA would be reported as 3/2/21 through 3/4/21.

- 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.