DASA
Medical
Benefits,
All Kids and
Family Care
Policy
Fly 2008
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INTRODUCTION

The information contained within this manual is applicable to any Medical Benefits, All Kids and Family Care. All providers shall be certified and enrolled to provide substance abuse treatment services as authorized by the Department of Human Services (DHS), Division of Alcoholism and Substance Abuse (DASA). Providers will bill Medical Benefits, All Kids and Family Care services as appropriate using the DARTS software. The policies and procedures contained within this manual are based upon those set forth in the Department of Healthcare and Family Services (HFS), Chapter 100 and rules and/or contract conditions in effect for Fiscal Year 2008. Where applicable, the specific source of the mandate is referenced. Providers can find Chapter 100 in its entirety at www.state.il.us/dpa/handbooks.htm.

The rates established to reimburse represent what DHS/DASA has determined it will pay for each service. However, the applicable rate may not always cover the actual cost of the service. Additionally, Medicaid payments made to providers for services to eligible participants are considered payment in full. If a provider accepts the patient as a Medical Programs participant, the provider may not charge eligible participants for co-payments, participation fees, deductibles, or any other form of patient cost-sharing, except as specifically allowed in Chapter 100. In no other instance may any form of patient cost-sharing be charged to eligible participants for any DASA covered services. Providers may not make arrangements to furnish more costly services or items than those approved by DASA for payment on condition that patients supplement payments made by DASA Medicaid.

Any patient’s treatment reimbursed by a third party provider (i.e., DASA contract, insurance, etc.) cannot be billed at a rate lower than the Medical Benefits, All Kids and Family Care approved rate for the individual service.

Full compliance with and a thorough understanding of DHS/DASA rules and procedures is expected of all providers who are certified to deliver Medicaid eligible substance abuse services. The majority of billing errors that cause delay or recoupment of payment can be prevented by correct utilization of reporting software and adherence to procedures established in this manual.
ELIGIBILITY - PROVIDER AND PATIENT

Provider Eligibility

To be eligible to bill for reimbursement, a provider must first have the correct certification by DHS/DASA and the correct corresponding enrollment with the Department of Healthcare and Family Services (HFS). The procedure for making application for certification is contained in DHS Rule, Part 2090. All completed enrollment applications must be sent to DHS/DASA.

In order to maintain eligibility, providers must deliver substance abuse services in accordance with DHS rules that specify:

- The minimum standards necessary to deliver quality care (Part 2060);
- The reimbursement limits as applicable for each level of care (Part 2090); and
- The minimum standards designed for administration of funding (Part 2030) as well as any other specific contractual obligations, if applicable.

Violations may result in financial penalty.

Patient Eligibility

In order to receive services that are reimbursed by DASA Medicaid, the patient must meet eligibility requirements under Title XIX and Title XXI (Medicaid) for covered services through the Medical Benefits, All Kids and Family Care. The eligibility status of such patients changes frequently. In order to reduce the incidence of billing error and/or recoupments, the provider must make every effort to verify the patient’s eligibility for the Medical Benefits, All Kids and Family Care PRIOR to service delivery. Learn the status of the patient’s eligibility using the patient’s MediPlan card, the card issued by the patient’s managed care organization, using one of the Department of Healthcare and Family Services’ Recipient Eligibility Vendors (REV) or by contacting the Provider Eligibility Inquiry Hotline at 1-800-842-1461. Specific information relative to HMO coverage and Spend Down requirements should also be verified.

Managed Care Enrollees Served by Community Substance Abuse Agencies

Effective April 1, 2000, policies and procedures were established regarding behavioral healthcare for persons enrolled in a Medicaid Managed Care Organization. Below please find steps for community substance abuse providers to follow when these patients present themselves for services. The determining factor for the provision of or the referral for treatment is the scope of services needed. Managed care networks are specific to northeastern Illinois (Cook County) and southwestern Illinois (Madison and St. Clair counties).

1. Learn the status of the patient’s eligibility using the patient’s MediPlan card, the card issued by the patient’s managed care organization, using one of the Department of Healthcare and Family Services’ Recipient Eligibility Vendors (REV) or by contacting the Provider Eligibility Inquiry Hotline at 1-800-842-1461.
2. Perform a clinical assessment to determine the scope of substance abuse services needed by the patient. This assessment should be in accordance with 77 Ill. Adm. Code 2060 Section 2060.417. Reimbursement will be made through the Division of Alcoholism and Substance Abuse in accordance with that rule.

3. If the assessment indicates that the only services needed are those the managed care organization is required to cover, the community based health provider (CBHP) will refer the individual to the managed care organization. If the individual refuses a referral, the CBHP must inform the individual that if they want to receive services through the CBHP, they must disenroll from the managed care organization. The CBHP must document its attempts to refer the individual to the managed care organization in the medical record. The Department of Healthcare and Family Services has a process to disenroll individuals on a case-by-case basis. The number to call is 1-800-226-0768. Managed care organizations provide inpatient hospitalization, pharmaceutical, laboratory and physician services including outpatient services.

4. If the assessment indicates that comprehensive behavioral health outpatient services, which may include physician/psychiatrist services are needed, the CBHP will treat the individual and be reimbursed through fee-for-service. The managed care organization will be responsible for payment of drugs prescribed by a licensed physician and laboratory services. The CBHP must inform the individual that prescriptions must be filled at a pharmacy in the managed care organization’s network. Laboratory services must be coordinated by the CBHP with the managed care organization.

5. Treatment of patients for substance abuse is confidential. Clinical information can only be shared with patient consent. This includes information to the patient’s primary care physician, the managed care plan or the plan’s behavioral health provider. The provider may utilize their standard forms and procedures for obtaining patient consent.

6. Any service the community provider renders should be communicated with the patient’s Managed Care provider or primary physician. This allows for continuity of care. Patient consent is required.

Medical Assistance Spend Down Information

A Medical Assistance Spend Down is much like an insurance deductible with three major exceptions:

1. The participant’s spend down is determined on a monthly basis.

2. The amount of that monthly spend down is based upon the participant’s income and assets.

3. When spend down is met in the middle of the month, the decision as to which bills are the patient’s responsibility and which are the Department’s is made chronologically based on the date of the service.
Although enrolled in the Medical Assistance program, spend down participants do not automatically receive a MediPlan card each month. MediPlan cards are only issued for the month (or portion thereof) for which participants have demonstrated that incurred or paid medical expenses equal the spend down by presenting medical bills and receipts to the local DHS office. A patient must incur a specified amount of medical bills before they can receive Medical Benefits, All Kids and Family Care coverage for a designated month. Each month, thereafter, spend down must be continued to be met for coverage to remain in effect. The provider may also want to contact the Provider Eligibility Inquiry Hotline at 1-800-842-1461 to check eligibility.
REIMBURSABLE SERVICES

Reimbursable Service
Covered services are specified in this section and are those that are generally recognized as reasonable and necessary for the diagnosis, care, treatment or rehabilitation of alcoholism and substance abuse as defined in 77 Ill. Adm. Codes 2060 and 2090. NOT all DHS/DASA covered services are reimbursable through the Medical Benefits, All Kids and Family Care. The following services are not covered:

1. Any service provided to an individual in a federal or state institution;
2. Residential extended care;
3. A sanctuary;
4. A recovery home;
5. Prevention programs;
6. Treatment in experimental programs;
7. Level III Inpatient domiciliary cost for adults in Level III care;
8. Level III Inpatient domiciliary cost for adolescents in Level III care that is not certified and enrolled as a Psych/Under 21 facility;
9. The cost of opioid maintenance therapy;
10. Case Management;
11. Early Intervention;
12. Community Intervention;
13. Toxicology; and

Covered Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Medical Benefits, All Kids and Family Care</th>
<th>Reimbursed</th>
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<tbody>
<tr>
<td>Admission and Discharge Assessment</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Level I</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Level III.7D (Medically Monitored Detoxification)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Level III.5 (Day Treatment)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Level III.5 (Residential Adolescent Rehabilitation)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Psychiatric/Diagnostic</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Medication Monitoring</td>
<td>Yes</td>
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</tbody>
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# FY 2008 Reimbursement Rates

Rates for services billed to Medical Benefits, All Kids and Family Care or Contract for FY 2008 are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Minimum Unit of Service</th>
<th>Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission and Discharge Assessment</td>
<td>Quarter Hour</td>
<td>-</td>
<td>$63.36 - per hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$15.84 - per quarter hour</td>
</tr>
<tr>
<td>Level I (Individual)</td>
<td>Quarter Hour</td>
<td>OP</td>
<td>$60.32 - per hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$15.08 - per quarter hour</td>
</tr>
<tr>
<td>Level I (Group)</td>
<td>Quarter Hour</td>
<td>OP</td>
<td>$22.80 - per hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$5.70 - per quarter hour</td>
</tr>
<tr>
<td>Level II (Individual)</td>
<td>Quarter Hour</td>
<td>OR</td>
<td>$60.32 - per hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$15.08 - per quarter hour</td>
</tr>
<tr>
<td>Level II (Group)</td>
<td>Quarter Hour</td>
<td>OR</td>
<td>$22.80 - per hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$5.70 - per quarter hour</td>
</tr>
<tr>
<td>Level III (Detoxification)</td>
<td>Daily</td>
<td>DX</td>
<td>Provider Specific</td>
</tr>
<tr>
<td>Level III.5</td>
<td>Daily</td>
<td>RR</td>
<td>Provider Specific</td>
</tr>
<tr>
<td>Psychiatric/Diagnostic</td>
<td>Per Encounter/Per Day</td>
<td>-</td>
<td>$78.94</td>
</tr>
<tr>
<td>Medication Monitoring (Individual)</td>
<td>Quarter Hour</td>
<td>OP/OR</td>
<td>$60.32 - per hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$15.08 - per quarter hour</td>
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Rates for eligible services are either uniform or provider specific. A provider may appeal a negotiated rate by following the procedure established in DHS Rule, Part 2090.80.
REIMBURSEMENT SPECIFICATIONS

Admission/Discharge

Admission - A clinical process that occurs after a patient has completed an assessment, received a recommendation for placement into a level of care and been accepted for such treatment. Covered services provided to patients whose assessment does not result in a substance abuse or dependence diagnosis cannot be billed.

Discharge - occurs when the patient’s treatment is terminated either by completion or by some other action initiated by the patient and/or organization. Providers cannot bill day of discharge for Residential Rehabilitation services to youth.

Group Counseling

Level I and II services delivered in a group setting shall be reimbursed only for 16 patients per counseling group supported by Department funding (Medicaid or contract).

Billings Linked to Level of Care

Billings should match the Level of Care for the patient. Outpatient care (Level I or II) cannot be billed on the same day as Residential care (Level III). Admission and discharge assessment, psychiatric evaluation and medication monitoring may be billed on the same day for any patient in any Level of Care in accordance with stated eligibility or exceptions.

Level III Care - Patient Day - No more than one patient day shall be reimbursed for any recipient in a 24-hour period.

Day of Discharge or Transfer - Level III - Billing for the day of discharge or transfer is allowable if services are delivered on that day. The day of discharge or transfer in a Residential Rehabilitation program cannot be billed. However, in accordance with the billing provisions specified above, only services in one Level of Care may be billed for per patient per day. For example, for any patient transferred to another level of care within the same organization, only one type of billing for services rendered that day will be allowed, i.e., if the patient was transferred from Level III care into Level I or II care and received both types of services on that same day, billing in this instance would be allowed for a Level III day treatment OR an hourly group or individual rate but not for both. Similarly, when a patient is discharged by one organization and transferred, via linkage agreement, to another organization for the same or a different level of care, only one organization may bill for service delivered on that day. The other provider may bill their contract if applicable. However, if the Medical Benefits, All Kids and Family Care were not billed, the referring and receiving organizations may both bill their contract for any services rendered on the day of discharge.

Psychiatric Evaluation

Such services are limited to the provision of a psychiatric evaluation to determine whether the patient’s primary condition is attributable to the effects of alcohol or drugs or to a
Reimbursement Specifications

diagnosed psychiatric or psychological disorder. Reimbursable psychiatric evaluations may be delivered to patients admitted to Level I through III care where need for such services is documented in the patient’s individualized treatment plan. Psychiatric evaluation shall be reimbursed at the established rate on a per encounter basis (one per day) to the psychiatrist.

Medication Monitoring
Medication monitoring must be billed at the individual counseling rate for patients in Level I, II and III care using the agency’s physician.

Billing Clarification for Methadone Patients
Medical Benefits, All Kids and Family Care - Providers can bill for Level I counseling services to DARTS if the site is certified and enrolled. Methadone providers who bill Level I services to the Medical Benefits, All Kids and Family Care must correctly report these services on DARTS using the Methadone unit number and program code which contains the standard Level I procedures code(s) (OPG, OPI, PEV).

In addition, eligible providers can also bill and receive reimbursement for Methadone patients who require Level II or III services even if they or another provider is receiving the case rate for outpatient Methadone services. In these instances, Methadone specific services that are considered part of the “all inclusive” case rate may not be part of the Level II and III care and must be delivered in addition to the Level II and III care.
BILLING REQUIREMENTS

Medical Benefits, All Kids and Family Care BILLING REQUIREMENTS

Certification
All provider sites and services eligible for the Medical Benefits, All Kids and Family Care reimbursement must be certified by DHS/DASA and enrolled with the Illinois Department of Healthcare and Family Services. The certification must specify which services are for adult or youth. Certification is granted by DASA according to criteria specified in Part 2090.

Enrollment
Each Medical Benefits, All Kids and Family Care certified provider must enroll each site with the Illinois Department of Healthcare and Family Services (HFS) prior to billing.

1. All services at one certified site should be enrolled under one provider number. As such, reimbursement is linked to the enrollment number and all reimbursement for all services at this site are contained on one voucher and one remittance advice.

In order to enroll, the provider must complete an enrollment package that is supplied at the time of certification. Upon completion, the enrollment package and a copy of the provider’s certification should be returned to DASA. Once the enrollment package is reviewed and accepted by DASA, it is forwarded to HFS with a memo indicating the certified procedure codes and corresponding rates.

In the event a provider requests to relocate an enrolled site, the following information will be required by DASA:

1. A copy of the revised DASA license/certificate;
2. Address of the previous site; and
3. Unit and program numbers involved in the relocation.

Enrollment Certification - Provider Information Sheet
Upon enrollment, HFS will send the provider a “Provider Information Sheet,” which lists all data carried on HFS’s computer files relative to enrollment. The provider should review this information for accuracy immediately upon receipt, especially the provider name and address. For an explanation of all entries on the form, see Appendix A. This information must be kept current and the provider and HFS share this responsibility.

Provider Responsibility: Information contained on the Provider Information Sheet is the same information which is carried on HFS files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy.
Procedure: The provider should enter the correct data in the space below the error and forward the corrected Provider Information Sheet to:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
Attention: Medicaid Liaison
Harris Building, Harris II
100 South Grand Avenue East, Second Floor
Springfield, Illinois 62762

Failure of a provider to properly notify the Department of corrections and/or changes may cause an interruption in participation and a delay in payments.

HFS Responsibility: Whenever there is a change in a provider’s enrollment status, an updated Provider Information Sheet will be generated and sent to the provider indicating the change and the effective date.

Covered Services

Providers should ensure that they are billing only for covered services or for those services identified in their award agreement (contract) with DASA.

Diagnosis and Procedure Codes

All claims require specific procedure codes and at least one diagnosis code as listed in the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM). If the patient is identified as a Mentally Ill/Substance Abuse (MISA) patient, one of the diagnosis codes must relate to MENTAL HEALTH.

Service Data Reporting (Billing)

Billing is accomplished electronically utilizing the Department’s Automated Reporting and Tracking System (DARTS). Appropriate software containing this system is provided free of charge. A flow chart outlining the steps in the billing process is included with this manual as Appendix B.

Providers may report DARTS and third party service data on a weekly basis but must report data at least monthly. Providers shall also report any other data so requested by DASA by the prescribed time lines. The preferred method of reporting service data is through software supplied by the Department. The Department assumes no responsibility for late, incomplete or inaccurate data produced by any software.

DASA may conduct random reviews to determine accuracy of provider’s service data. The provider shall be able to verify data entries upon request.

The provider agrees to notify DASA immediately through a written request to the Help Desk DHS.DASAHHELP@ILLINOIS.GOV upon discovery of any problem relative to the submission of any required service or financial data.
Billing Requirements

**Data Reports**

All services submitted for payment will appear on a DHS accepted/rejected report. All rejected services will have an error message associated with the rejection. These reports should be reviewed and reconciled upon receipt.

Services submitted for reimbursement can also be rejected during processing at HFS. In these instances, rejections are identified on a remittance advice with an error code and a descriptive error message.

In all instances, if an error occurs and the service can be rebilled, the service should be resubmitted utilizing DARTS. **Providers should remember that services must be resubmitted in a timely manner.**

If an adjustment is necessary to a paid claim, it is necessary to complete a HFS Hospital Adjustment form 2249. Instructions for completion are contained in **Appendix C.** A specific listing of error codes and procedures are specified in **Appendix D.**

**Procedures for Processing Year Old Medical Benefits, All Kids and Family Care Claims**

Claims for reimbursement should be submitted monthly through DARTS and as close to the date of service as possible. This allows for any errors to be identified and fixed and makes timely re-submission possible. As specified in Part 2090.35, Medical Benefits, All Kids and Family Care reimbursement allows claims to be paid if processed within 12 months of the date of service. "Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures" further states that the 12-month time frame is applicable to both initial and previously rejected claims. When services over 12 months old are submitted to DASA, the procedure is as follows:

1. All requests by providers to submit claims that are later than 12 months from the date of service shall be in writing and addressed to DASA. The request should include the reason why the claims were not submitted or paid in a timely manner. Supporting documentation should be attached if applicable.

2. DASA will review the letter and supporting documentation to determine if the delay in submission was due to DASA or HFS delays in processing.

3. **If the delay in claim submission was not due to DASA or HFS delays in processing, the request will be denied.**

4. If it is determined that delays were due to DASA or HFS processing, the provider will be notified.

5. Payment of these claims shall be done within DASA’s appropriation authority.

6. **Any request to process a claim that is more than two years from the date of service shall be denied.**
APPENDICES
APPENDIX A - Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced whenever a provider is enrolled in the Illinois Medicaid Management Information System (MMIS). It will also be generated every time there is a change or update to the provider record. This sheet is mailed back to the provider and serves as a record of all the data that appears on the Provider Database.

The following information will appear on the Provider Information Sheet. An explanation of the field follows the field name.

1. **Provider Key**
   This number uniquely identifies the provider at HFS. This Medicaid provider number is used for processing claims.

2. **Provider Name and Address**
   Name and address of the provider as it appears on the Provider Database.

3. **Provider Type**
   A three-digit code and the corresponding narrative indicating the provider’s classification.

4. **Organization Type**
   A two-digit code and the corresponding narrative indicating the legal structure of the environment, in which the provider primarily performs services. For A/SA treatment providers, code 01 will always be used.

5. **Enrollment Status**
   A one-digit code and the corresponding narrative indicating whether or not the provider is currently an active participant in the Illinois Medical Assistance Program. The possible codes are:
   - B = Active
   - I = Inactive
   - R = Rejected

6. **Begin (Enrollment Status)**
   Date indicating when the provider was most recently enrolled in Illinois MMIS.

7. **End (Enrollment Status)**
   Date indicating the end of the provider’s most current enrollment period. If currently enrolled, the word “active” will be shown.

8. **Exception Indicator**
   A one-digit code and the corresponding narrative indicating that the provider claims will be reviewed manually prior to payment. The possible codes are:
   - A = Exception Requested by Audits
   - B = Pseudo Number Abuse
   - C = Citation
   - G = Garnishment
   - N = No Exception
Appendix A - Explanation of Information on Provider Information Sheet

S = Exception Requested by Provider Services
T = Tax Levy

9. **Begin (Exception Indicator)**
   Date indicating the first day the provider’s claims are to be manually reviewed.

10. **End (Exception Indicator)**
    Date indicating the last day the provider’s claims are to be manually reviewed.

11. **Certificate/License Number**
    A unique number identifying the certificate issued authorizing a provider to become enrolled in the Illinois Medicaid Program.

12. **Ending (of Certificate/License Number)**
    Date indicating when the certificate will expire.

13. **County**
    The three-digit code identifying the county, in which the provider maintains its primary office location. It is also used to identify a state if the provider’s primary office location is outside of Illinois.

14. **DEA # (Drug Enforcement Agency Number)**
    A number assigned by the Federal Drug Enforcement Administration as a means of identifying practitioners or other prescribers and dispensers of drugs and controlled substances.

15. **Telephone Number**
    The telephone number of the provider’s primary office.

16. **Last Transaction**
    A three-digit code indicating the last type of update made to the provider’s record. The possible codes are:
    
    ADD = Add
    CHG = Change
    DEL = Delete
    COR = Correct

17. **As-of (Last Transaction)**
    Date of last update made to Department records.

18. **Medicare Number**
    The number assigned to the provider by Medicare. (This does not apply to A/SA treatment providers at this time).

19. **Facility Control/Affiliation**
    A two-digit code and the corresponding narrative indicating the ownership of the health and medical services facilities. The possible codes are:
    
    01 = Public (State, County, Federal)
    02 = Charitable or Religious Organization
    03 = Proprietary (Privately owned)
04 = Other

20. **Social Security Number**
   Does not apply for A/SA providers.

21. **Fiscal Year End**
   Date on which the provider’s fiscal year ends.

22. **Pharmacy Affiliation**
   Does not apply to A/SA treatment providers.

23. **Eligibility Category of Service**
   A three-digit code and the corresponding narrative indicating the types of service a provider is authorized to render to a recipient. The code for A/SA services is 035.

24. **Begin-Elig-End**
   Begin and end dates during which the provider has been approved to render services.

25. **Termination Reason**
   A one-digit code and the corresponding narrative indicating the reason for a provider’s termination of eligibility to render a service to a recipient. The possible codes are:
   
   1 = Voluntary Termination
   2 = Termination by HFS
   3 = License Decertification
   4 = Death
   5 = Financial Disclosure Not on File
   6 = Medicare Termination
   7 = Closed Due to Inactivity
   8 = Other
   9 = Dis-enrolled
   R = Closed due to expired license

26. **Payee**
   List of payees authorized to receive warrants on behalf of the provider.

27. **Payee Name**
   The name of the person or entities designated to receive payment on behalf of the provider.

28. **Payee Street**
   The street of the mailing address of the designated payee.

29. **Payee City**
   The city of the mailing address of the designated payee.
30. **Payee State**  
The two-digit postal abbreviation of the state of the mailing address of the designated payee.

31. **Payee Zip**  
The zip code of the mailing address of the designated payee.

32. **Payee ID Number**  
Sixteen-digit identification number assigned to each payee to whom warrants may be issued. This is not the Medicaid provider number.

33. **Eff Date**  
Date indicating the effective date when payment can be made to the payee on behalf of the provider.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, line out the error and note the correct information in the space below the error and return the document to DASA to the attention of the DASA Medicaid Liaison. If all the information on the sheet is correct, the provider is to keep the document for reference when completing Medicaid adjustment forms. (HFS 2249)
APPENDIX B - PAYMENT AND DATA PROCESSING CYCLE FLOW CHART

JULY 2007

User enters data into DARTS software as services are provided

Users pull and submit data to DHS weekly but at least monthly

DHS edits and balances data weekly against existing files (rate, pharmacy, reimbursement) and weekly mails to the provider a diskette containing transaction errors

DHS creates and sends tape containing Medicaid billings for submission to Department of Healthcare and Family Services (HFS)

DHS processes DARTS service data

HFS processes DHS Medicaid tape

Reports created for use by DASA staff for review of programmatic contract compliance (15th–19th working days of each month)

Reports created for use by providers (15th–19th working days of each month)

Reports distributed to DASA staff (20th working day of each month)

DARTS Reports and Medicaid Eligibility Report mailed to providers (20th working day of each month)

HFS sends all processed Medicaid claims and remittance advices to the Office of the Comptroller and creates and mails weekly error reports to providers (which alert providers to errors that will be contained on the remittance advice)

Comptroller mails remittance advice and payment to providers

Reports distributed to DASA staff (20th working day of each month)

DHS sends all processed Medicaid claims and remittance advices to the Office of the Comptroller and creates and mails weekly error reports to providers (which alert providers to errors that will be contained on the remittance advice)

Comptroller mails remittance advice and payment to providers
APPENDIX C - Instructions for Completing the Medical Benefits, All Kids and Family Care Payment Adjustment Form

General Instructions

Form (HFS 2249) is to be used in one of two circumstances:

1. to correct any claim for which payment has been made, and the payment was more than or less than the amount which should have been received; or
2. to void payment of a claim, which was submitted and paid, for an incorrect procedure code or the incorrect number of days or units. (After the voiding adjustment has been reported on a Remittance Advice, the service can be rebilled with the correct information).

The Payment Adjustment Form is always submitted after the recipient’s claim has been processed and has been reported on the Remittance Advice as "Paid" or "Reduced." Several data items on this form must be completed using exact information as shown on the recipient’s original claim. These items are included in the specific instructions given below.

When completed, tear off and retain the yellow copy. Submit the rest to the following address:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
Medicaid Liaison
Harris Building, Harris II
100 South Grand Avenue East, Second Floor
Springfield, Illinois 62762

The green copy will be returned to the provider to show that the claims adjustment form has been received. When the adjustment has been processed, the remittance advice will show that the transaction has been completed.

Specific Instructions

Item 1 - Document Control Number
   Always leave blank.

Item 2 - Provider Name and Address
   Enter the provider name and address exactly as it appears on the Provider Information Sheet.

Item 3 - Provider Number
   Enter the Medicaid provider number exactly as it appears on the Provider Information Sheet.
Appendix C - Instructions for Completing the Medical Benefits, All Kids and Family Care Payment Adjustment Form

**Item 4 - Payee**
Always enter 1.

**Item 5 - Provider Reference (Optional)**
Enter the recipient’s medical record number or patient control number utilized in your accounting system for identification purposes.

**Item 6 - Voucher Number**
Enter the voucher number from the original paid claim as shown on the Remittance Advice.

**Item 7 - Document Control Number**
Enter the Document Control Number from the original paid claim as shown on the Remittance Advice.

**Item 8 - Unlabeled**
Always leave blank.

**Item 9 - Date of Service**
Enter the last paid date of service from the original paid claim.

**Item 10 - Unlabeled**
If the form is used to correct an erroneous prior payment, enter the procedure code that was used on the original claim.

**Items 11, 12 and 13 - Recipient Name, Number and Date of Birth**
Enter the recipient name and recipient number exactly as it appears on the Remittance Advice. Enter the recipient’s date of birth exactly as it was on the original claim submitted.

**Item 14 - Adjustment Type**
Always enter 02.

**Items 15 and 16 - Unlabeled**
Always leave blank.

**Item 17 - Charges**
Enter the amount of the payment which was received as it appears on the Remittance Advice.
Item 18 - TPL
If the recipient has insurance (third party liability or TPL), enter the three-digit code for the insurance company found in Chapter 100, General Appendix 9. If the adjustment is made for a change in the recipient’s spend down amount, enter 906.

Item 19 - TPL Amount
Enter the amount paid by the recipient's insurance or, if the recipient is subject to spend down requirements, enter the spend down amount the recipient has paid or for which the recipient has unpaid bills.

Item 20 - Reason Adjustment Requested
Give the reason for which the adjustment is being requested, using as much specificity as possible. Include the name and telephone number of a provider contact person.

Items 21 and 22 - Provider Signature and Date
The form must be signed and dated by the provider’s authorized representative, using the date on which the form was completed.
APPENDIX D - Error Codes and Procedures

Error codes are reported to providers on Form HFS 194-M-I, Remittance Advice. A three-character code appears in the farthest column to the right. An error message will appear on the same line directly under each service section(s), starting in the Category of Service Column. The error code is the key to identifying specific procedures for the resolution of errors. Providers must review error messages and take corrective action.

Current error codes and procedures follow. If an error code appears on a remittance advice that is not on this list, please contact the Medicaid Liaison for substance abuse services.

"C" SERIES - VALIDATION ERRORS
The "C" series errors indicate that HFS is unable to process the particular service due to incorrect or insufficient information. Review the billing instructions to determine proper field content and requirements.

<table>
<thead>
<tr>
<th>ERROR</th>
<th>MESSAGE</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>C31</td>
<td>Procedure not on file for date</td>
<td>Review procedure codes billed ensuring procedure codes listed are valid for the dates of service being billed. If valid code was originally used, contact your DHS representative.</td>
</tr>
<tr>
<td>C32</td>
<td>Procedure illogical for category of service</td>
<td>Review procedure codes billed ensuring procedure codes listed are valid. If valid code was originally used, contact your DHS representative.</td>
</tr>
</tbody>
</table>

"D" SERIES - MISCELLANEOUS ERRORS
The "D" series of errors includes miscellaneous errors not otherwise listed. Review applicable billing instructions to determine proper field content and resubmittal requirements.

<table>
<thead>
<tr>
<th>ERROR</th>
<th>MESSAGE</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D01</td>
<td>Duplicate payment voucher</td>
<td>An invoice was received which was a duplicate of one previously processed. If the claim was not previously paid, contact your DHS representative.</td>
</tr>
<tr>
<td>D05</td>
<td>Submitted later than one year after service</td>
<td>DHS and/or HFS will not consider for payment any claim received for charges more than 12 months from the date of service. If the service date is more than one year prior to HFS’ receipt of claim, the claim will be rejected.</td>
</tr>
</tbody>
</table>
## Appendix D - Error Codes and Procedures

<table>
<thead>
<tr>
<th>ERROR</th>
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</tr>
</thead>
<tbody>
<tr>
<td>D22</td>
<td>NO claim found to be adjusted</td>
<td>Review adjustment form that was submitted to ensure it was to adjust services that were previously paid. If dates are incorrect, submit new adjustment form. If adjustment originally submitted appears correct, contact your DHS representative.</td>
</tr>
<tr>
<td>D23</td>
<td>Duplicate adjustment found for this claim</td>
<td>A previous adjustment was submitted on the same original claim.</td>
</tr>
<tr>
<td>D97</td>
<td>Denied adjustment</td>
<td>Adjustment submitted is being denied. Contact your DHS representative.</td>
</tr>
</tbody>
</table>

### "P" SERIES - PROVIDER ERRORS

The "P" series of errors identifies problems associated with provider eligibility. In order to receive payment under the Medical Assistance Program, a provider must be approved for participation and be enrolled to provide the specific category of service for which charges are made.

<table>
<thead>
<tr>
<th>ERROR</th>
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<tbody>
<tr>
<td>P03</td>
<td>Provider not enrolled for category of service; date of service</td>
<td>A charge was submitted for which the date of service either precedes the effective date of the provider’s enrollment for the category of service or is subsequent to the termination of participation for the applicable category of service. Review records to verify that dates of service were entered correctly. If incorrect dates were entered, submit corrected claim. If an error cannot be corrected, the provider is to review the Provider Information Sheet for the correctness of beginning and ending enrollment dates for the category of service provider. If the enrollment dates on the Provider Information Sheet appear incorrect, the provider should contact the DHS representative.</td>
</tr>
<tr>
<td>P05</td>
<td>Provider number not on file</td>
<td>This number should be the exact number as it appears on your Provider Information Sheet from HFS. If incorrect number was submitted, resubmit corrected claim. If original number is correct, contact your DHS representative.</td>
</tr>
</tbody>
</table>
## Appendix D - Error Codes and Procedures

### ERROR MESSAGE PROCEDURE

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>P06</td>
<td>Provider name does not match provider number</td>
<td>Submit corrected claim with provider name as registered with HFS. Review claim to verify that provider name and number agree and are entered as shown on the Provider Information Sheet.</td>
</tr>
</tbody>
</table>

### "R" SERIES - PROGRAM PARTICIPATION ERRORS

The "R" series of errors indicates that payment cannot be allowed on behalf of the patient for specific services provided on a specific date. By reviewing the exact rejection, the provider can determine what action should be taken. Review billing instructions to determine proper field content and resubmittal requirements.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>R02</td>
<td>Recipient name does not match recipient number</td>
<td>The patient name and number does not match. Submit a new claim with correct information. Recipient name and number must appear exactly as on MediPlan Card.</td>
</tr>
<tr>
<td>R03</td>
<td>Recipient not eligible on date of service</td>
<td>An invoice was received for a date of service which does not fall within the range of the patient’s medical eligibility period. Review the patient’s MediPlan Card to ensure the correct recipient number was used for dates of service being billed. Contact the local DHS office for assistance. If the local DHS office confirms the patient was not eligible on the dates of service, the patient is liable for payment of services. If the provider can obtain proof of eligibility at the time of service, contact your DHS representative.</td>
</tr>
<tr>
<td>R06</td>
<td>Spend down not met</td>
<td>Recipient not eligible on date of service due to an unmet spend down. Verify patient’s eligibility by checking eligibility dates on patient’s MediPlan card. If patient is not eligible on date of service, do not rebill.</td>
</tr>
<tr>
<td>R10</td>
<td>Services not covered for recipient’s category</td>
<td>Review recipient category as identified in the Case Number listed on the Medical Eligibility Document of the recipient. Submit a new invoice including correct information. If no billing error occurred, do not rebill.</td>
</tr>
<tr>
<td>R17</td>
<td>Service invalid for recipient age</td>
<td>An invoice was received with a diagnosis, procedure, or revenue code denoting services which are not covered for patient’s age.</td>
</tr>
</tbody>
</table>
### Appendix D - Error Codes and Procedures

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<tbody>
<tr>
<td>R36</td>
<td>Recipient has part B Medicare</td>
<td>Bill needs to be submitted to Medicare for payment.</td>
</tr>
<tr>
<td>R66</td>
<td>QMB recipient only-not eligible for Medicaid</td>
<td>On the date of service, the patient is a QMB recipient and eligible for payment of Medicare co-insurance and deductible only. Provider should bill Medicare.</td>
</tr>
</tbody>
</table>