2021

FISCAL YEAR

Division of Substance Use Prevention and Recovery (SUPR) Policy Manual for Participants Covered Under the Department of Healthcare and Family Services Medical Programs

ILLINOIS DEPARTMENT OF HUMAN SERVICES

Division of Substance Use Prevention and Recovery

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Introduction

The information contained within this manual is applicable to the participant eligibility categories identified in General Appendix 5 of the Department of Healthcare and Family Services (HFS) Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures. All organizations shall be certified and enrolled to deliver substance use disorder treatment services as authorized by the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR). Organizations will bill services as appropriate using the Department's Automated Reporting and Tracking System (DARTS) software. The policies and procedures contained within this manual are based upon those set forth in Chapter 100 and rules and/or contract conditions in effect for Fiscal Year 2021. Where applicable, the specific source of the mandate is referenced. Organizations can find Chapter 100 in its entirety on the HFS website.

The rates established to reimburse represent what IDHS/SUPR 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 organizations for services to eligible participants are considered payment in full. If an organization accepts the patient as a Medical Programs participant, the organization 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 SUPR covered services. Organizations may not decide to furnish more costly services or items than those approved by SUPR for payment on condition that patients supplement payments made by SUPR Medicaid.

Any patient's treatment reimbursed by a third-party (i.e., SUPR contract, insurance, etc.) cannot be billed at a rate lower than the HFS Medical Programs approved rate for the individual service.

Full compliance with and a thorough understanding of IDHS/SUPR rules and procedures is expected of all organizations who are certified to deliver Medicaid eligible substance use disorder services. Most 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 – Organization and Patient

Organization Eligibility

To be eligible to bill for reimbursement, an organization must first have the correct certification by IDHS/SUPR and the correct corresponding enrollment with the Department of Healthcare and Family Services (HFS). The procedure for making application for certification is contained in IDHS Rule, 77 Illinois Administrative Code, Part 2090. All completed enrollment applications must be submitted through the IMPACT system at https://www.illinois.gov/hfs/impact/Pages/default.aspx.

In order to maintain eligibility, organizations must deliver substance use disorder treatment services in accordance with IDHS 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 SUPR Medicaid, the patient must meet eligibility requirements under Title XIX (Medicaid Program) and Title XXI (Children's Health Insurance Program) for covered services. The eligibility status of such patients can change frequently. In order to reduce the incidence of billing error and/or recoupments, the organization must make every effort to verify the patient's eligibility PRIOR to service delivery. Learn the status of the patient's eligibility using the MEDI (Medical Electronic Data Interchange) system by enrolling in MEDI at https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx, REV (Recipient Eligibility Vendor) or through the AVRS (Automated Voice Response System) by calling 1-800-842-1461. HFS currently produces semi-permanent durable medical cards. Therefore, it is imperative that all organizations check the status of a patient's eligibility through one of the above systems. **Specific information relative to Managed Care Organization (MCO) coverage and Spenddown requirements should also be verified.**

Managed Care Enrollees Served by Community Substance Use Disorder Treatment Agencies

There are currently two managed care programs serviced by Community Substance Use Disorder organizations. These managed care programs serve various Medicaid populations throughout Illinois. The managed care organizations (MCOs) who have contracted with the Department of Healthcare and Family Services (HFS) may serve Medicaid beneficiaries in one or more of the two managed care programs.

The HealthChoice Illinois program is a mandatory managed care program. It operates statewide for most Illinois Medicaid recipients who receive full Medicaid benefits.

The Medicare Medicaid Alignment Initiative (MMAI) is a passive enrollment managed care program for persons ages 21 and older who are eligible for full Medicaid and full Medicare benefits. This population is often referred to as "dual-eligible". This managed care program combines all Medicaid and Medicare

covered services under one MCO. MMAI operates in two regions in Illinois. Beneficiaries can choose to participate or opt out of this managed care program.

To find out more about the Medicaid managed care programs, their contract requirements, MCO information, etc., please see the HFS Care Coordination Webpage: https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx. The Medicaid Managed Care Program Map can also be found on this website. https://www.illinois.gov/hfs/SiteCollectionDocuments/StatewideHealthChoiceIllinoisPlans.pdf.

When a person is enrolled in HealthChoice Illinois or MMAI presents themselves for services, their eligibility status in the system will reflect which MCO they are enrolled in. The enrollee should also have an identification card from that MCO. If your agency is part of the MCO's provider network, you should deliver services according to the MCO procedures. If your agency is not part of the MCO's provider network, you should contact the MCO prior to delivering services. To learn more about identifying the enrollee's health plan, please refer to the HFS provider notice released on 3/9/15: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn150309a.aspx.

Medical Assistance Spenddown Information

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

1. The participant's spenddown is determined on a monthly basis.
2. The amount of that monthly spenddown is based upon the participant's income and assets.
3. When spenddown 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.

Spenddown participants will receive a new HFS Medical Card upon enrollment. The card will be issued regardless of the spenddown being met or unmet. Participants must have incurred or paid medical expenses equal to the spenddown and present those medical bills and receipts to their local Family Community Resource Center (FCRC). The patient may only be eligible for a portion of a month, depending on the date the spenddown is met. Each month, thereafter, spenddown must continue to be met for coverage to remain in effect. The organization may learn the status of the patient's eligibility using the MEDI/REV/AVRS by calling 1-800-842-1461 or enrolling in the MEDI system at https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx.

Reimbursable Services

Reimbursable Services

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 substance use disorder as defined in 77 Ill. Adm. Codes 2060 and 2090. **Not all IDHS/SUPR covered services are reimbursable through HFS's Medical Programs.** The following services are not covered:

1. Any service provided to an individual in a federal or state institution;
2. Level 3.1 care – Clinically managed low-intensity residential;
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. Case Management;
10. Early Intervention;
11. Community Intervention;
12. Toxicology; and
13. Child Care.

FY 2021 Covered Services and Reimbursement Rates

Rates for services billed to HFS's Medical Programs or Contract for FY 2021 are as follows:

Service	Minimum Unit of Service	Code	Rates
Admission and Discharge Assessment	Quarter Hour	-	$70.36 – Per Hour $17.59 – Per Quarter Hour
Level 1 (Individual)	Quarter Hour	OP	$66.92 – Per Hour $16.73 – Per Quarter Hour
Level 1 (Group)	Quarter Hour	OP	$25.36 – Per Hour $ 6.34 – Per Hour
Level 2 (Individual)	Quarter Hour	OR	$66.92 – Per Hour $16.73 – Per Quarter Hour
Level 2 (Group)	Quarter Hour	OR	$25.36 – Per Hour $ 6.34 – Per Quarter Hour
Level 3.7 (Withdrawal Management) As of 9/1/20	Daily	DX	FFS $346.80 Per Diem Encounter $408.00 Per Diem
Level 3.5 Adult As of 9/1/20	Daily	RR	FFS $222.21 Per Diem Encounter $261.42 Per Diem
Level 3.5 Adolescent PRTF As of 9/1/20	Daily	RR	FFS $376.90 Per Diem Encounter $376.90 Per Diem
Level 3.5 Adolescent As of 9/1/20	Daily	RR	FFS $320.37 Per Diem Encounter $376.90 Per Diem
Psychiatric/Diagnostic	Per Encounter/Per Day	-	$87.60 – Per Encounter/Per Day
Medication Monitoring (Individual)	Quarter Hour	OP/OR	$66.92 – Per Hour $16.73 – Per Quarter Hour
Methadone as an Adjunct to Treatment	Weekly	OP	$75.40 – Weekly

Medicaid fee for service or MCO, whichever is applicable, must be billed if both the patient and the service are Medicaid eligible. SUPR contract funds shall not be accessed if the patient 's service can be reimbursed through Medicaid.

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 use disorder 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. Organizations cannot bill day of discharge for level 3 services.

Group Counseling

Level 1 and 2 services delivered in a group setting shall be reimbursed for a maximum of 16 patients per **counseling** group supported by Medicaid or IDHS/SUPR contract.

Billings Linked to Level of Care

Billings should match the Level of Care for the patient. Outpatient care (Level 1 or 2) cannot be billed on the same day as Residential care (Level 3). 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 3 Care – Patient Day – No more than one patient day shall be reimbursed for any participant in a 24-hour period.

Day of Discharge or Transfer – Level 3 – Billing for the day of discharge or transfer is not allowable.

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 diagnosed psychiatric or psychological disorder. Reimbursable psychiatric evaluations may be delivered to patients admitted to Level 1 through 3 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). This service must be delivered by the agency's psychiatrist, an enrolled Advanced Practice Nurse (APN) who holds a current certification in Psychiatric and Mental Health Nursing as set forth in 68 Ill. Adm. Code 1300 Appendix A and is practicing in accordance with the Nurse Practice Act; a Licensed Clinical Psychologist (LCP); or a Licensed Clinical Social Worker (LCSW).

Medication Monitoring

Psychotropic medication monitoring must be billed at the individual counseling rate for patients in Level 1, 2 and 3 care. Psychotropic medication monitoring includes a review of the efficacy, dosage and side effects of any psychotropic medication used by the patient. This type of medication monitoring shall also be conducted by the agency's physician or psychiatrist or physician extenders as described in the SUPR Smart Alert located here: https://www.dhs.state.il.us/page.aspx?item=97923 and billed at the individual counseling rate.

Billing Requirements

HFS Medical Programs Billing Requirements

Certification

All organization sites and services eligible for HFS Medical Programs reimbursement must first be certified by IDHS/SUPR and then enrolled with HFS. The SUPR Medicaid certification must specify which services are for adult or youth. Certification is granted by SUPR according to criteria specified in Part 2090.

Enrollment

Each SUPR Medicaid certified organization must enroll each certified site with the Illinois Department of Healthcare and Family Services (HFS) **prior to billing**.

1. All services under one certified license should be enrolled under one NPI and organization number. As such, reimbursement is linked to the NPI and enrollment number and all reimbursement for all services at this site is contained on one voucher and one remittance advice.
2. If your organization will be billing Medicaid from an off-site location, this location is required to enroll if the following criteria apply:
   - The off-site location is owned or leased by the organization; or
   - The off-site location has managing and/or assigned staff at the location; or
   - Patients need to travel to the off-site location to receive services rather than organization staff going to them.

In order to enroll, the organization must complete an electronic HFS IMPACT enrollment application. Upon completion, the application will be first reviewed by SUPR, then by HFS. Once the application

is reviewed and accepted by SUPR, a memo indicating the certified procedure codes and corresponding rates is sent to HFS.

Enrollment Certification – Provider Information Sheet

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

> *Organization Responsibility*: Information contained on the Provider Information Sheet is the same information, which is carried on HFS files. Each time the organization receives a Provider Information Sheet, it is to be reviewed carefully for accuracy.

Procedure: The organization 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 Substance Use Prevention and Recovery
Attention Medicaid Liaison
600 East Ash Street
Building 500, Third Floor North
Springfield, Illinois 62703

Or: DoIT.SUPRHelp@illinois.gov

Failure of an organization to properly notify SUPR of any corrections and/or changes may cause an interruption in participation and a delay in payments.

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

Covered Services

Organizations should ensure that they are billing only for covered services or for those services identified on their Medicaid certification.

Diagnosis and Procedure Codes

All claims require specific procedure codes and at least one SUD diagnosis code as listed in the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-10-CM). If the patient is identified with a co-occurring disorder, one of the diagnosis codes must relate to MENTAL HEALTH.

Service Data Reporting (Billing)

Fee for service billing is accomplished electronically utilizing 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.**

A DARTS file is sent to each organization at the beginning of each fiscal year with the billable locations and services for that year. These are sent via email to the organization's Authorized Organization Representative (AOR). This person is responsible for forwarding the file to any staff who needs this to bill. It is also the responsibility of each organization to review the information on the unit/program file and notify SUPR of any missing or incorrect information. Throughout the year, any revisions that occur to the DARTS file will also be sent to the AOR.

Organizations may report DARTS and third-party service data on a weekly basis but must report data at least monthly. Please note that all Medicaid claims must be billed within 180 days of the date of the service. Organizations shall also report any other data so requested by SUPR by the prescribed timelines. The preferred method of reporting service data is through software supplied by SUPR. The Department assumes no responsibility for late, incomplete, or inaccurate data produced by any software.

SUPR may conduct random reviews to determine accuracy of service data. The organization shall be able to verify data entries upon request.

The organization agrees to notify SUPR immediately through a written request to the Help Desk DoIT.SUPRHelp@illinois.gov upon discovery of any problem relative to the submission of any required service or financial data.

Please note that all Medicaid Managed Care billing is submitted directly to the respective MCO. However, demographic data for any patient whose services are billed through the MCO must be entered into DARTS and submitted to IDHS/SUPR.

Data Reports

All services submitted for payment will appear on an IDHS accepted/rejected Mobius 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. Organizations **should remember that services must be resubmitted in a timely manner. All resubmissions are also subject to the 180-day billing timeline with the initial date of service.**

If an adjustment is necessary to a paid claim, providers must complete an HFS 2249 – Hospital Adjustment form. This form is available in PDF fillable form at https://www.illinois.gov/hfs/SiteCollectionDocuments/hfs2249.pdf. Instructions for completion are contained in **Appendix C.** A specific listing of error codes and procedures are specified at https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx.

Late Payment/Services Submission

SUPR has two established billing periods:

1. Medicaid Funds: Medicaid funds can be paid if accepted for payment and processed within 180 days of the date of service and if the bill does not exceed the established fiscal year obligation.
2. All Other SUPR Funds: Any other SUPR funds can be paid if they are delivered within the applicable state fiscal year, accepted for payment before annually established dates relative to the end of the lapse period and do not exceed the established fiscal year amount of funding contained in the contract.

Payment or Acceptance of Services beyond Established Billing Periods:

- Requests for payment or service acceptance beyond established billing periods are allowable if the delay in submission was due to SUPR or Healthcare and Family Services (HFS) processing.
- Requests for service acceptance or reimbursement from SUPR funds other than Medicaid may only be submitted for the prior state fiscal year. Requests for reimbursement from Medicaid may only be submitted up to two years from the date of service. All requests shall be in writing and include the reason the established billing period was exceeded. Supporting documentation must be attached. All requests must also adhere to the conditions specified in the SUPR contract, applicable manuals

and/or letter of agreement or memorandum of understanding. If the request is for reimbursement from a federal project fund, it must reference the federal grant fiscal year funding as specified in the SUPR contract. All other requests for reimbursement shall be for the same type of program funds identified in the SUPR contract.

If the request is denied, it will be for one of the following reasons:

- It is determined that the delay in submission is not the fault of SUPR or HFS.
- Insufficient funds to satisfy the request in the specific project or program area.
- No availability of funds within SUPR' s appropriation authority.

- If the request for non-Medicaid funds is approved, SUPR will apply the appropriate service credit or approve the services for reimbursement from the Illinois Court of Claims. All such approvals are subject to on-site and/or electronic audit. All requests will be responded to in writing and will specify the reason for the denial or acceptance.
- If the request is for SUPR Medicaid funds, the organization will be required to complete an approved HFS form for each Medicaid claim and send to HFS for processing. All such approvals are subject to on-site and/or electronic audit. All requests will be responded to in writing and will specify the reason for the denial or acceptance.

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 filed 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. **Begin (Enrollment Status)**
   A one-digit code and the corresponding narrative indicating whether 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

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 currently).

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 participant. 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 participant. 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.

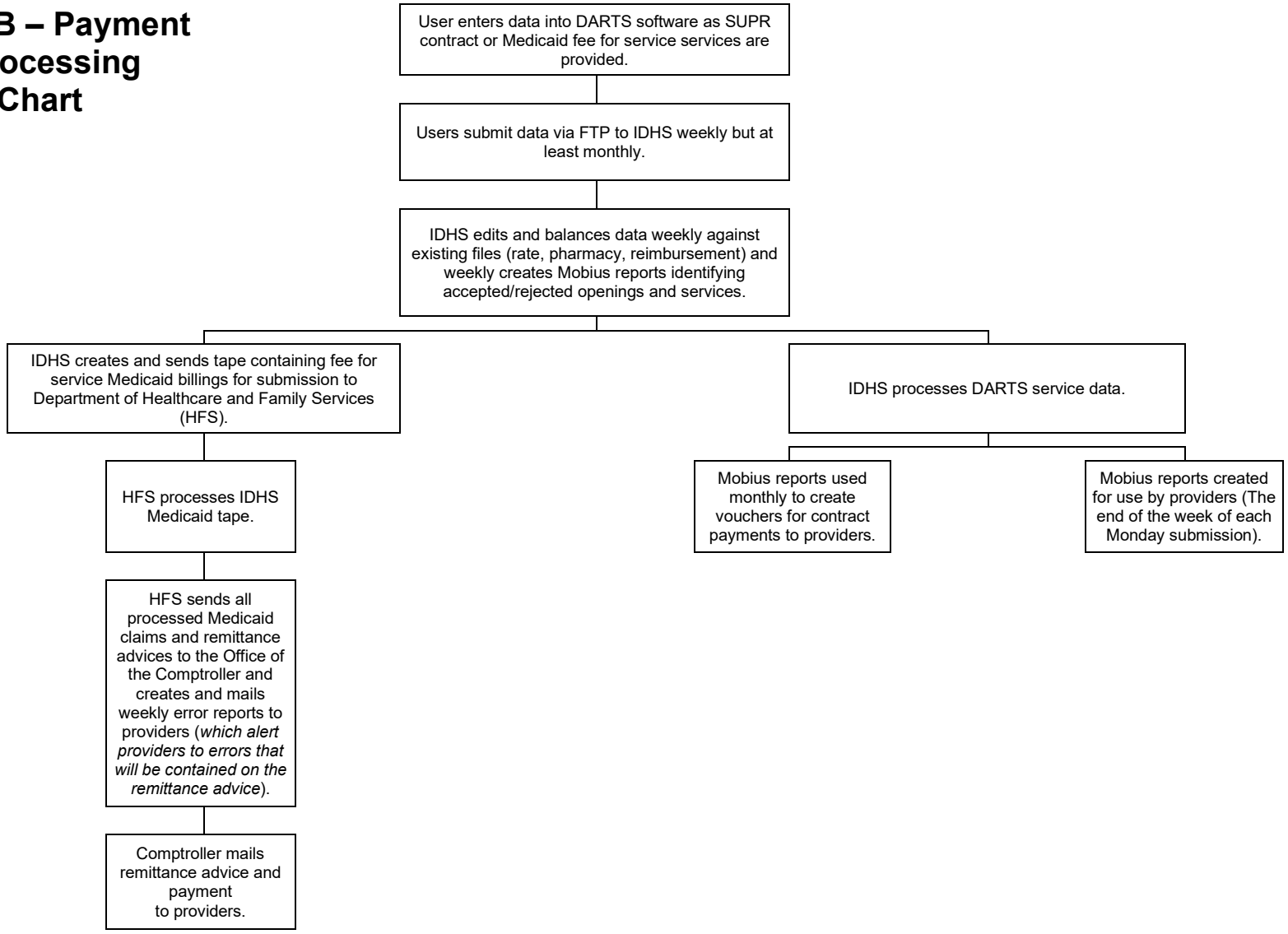
31. **Payee Zip**
    The zip code of the mailing address of the designated payee.

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 organization 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 SUPR to the attention of the SUPR Medicaid Liaison. If all the information on the sheet is correct, the organization is to keep the document for reference when completing Medicaid adjustment forms. (HFS 2249)

APPENDIX B – Payment and Data Processing Cycle Flow Chart



APPENDIX C – Instructions for Completing the HFS 2249 – Hospital 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 participant'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 participant's original claim. These items are included in the specific instructions given below.

When completed, make a copy of the adjustment prior to sending for processing. Submit the form to the following address:

Illinois Department of Human Services
Division of Substance Use Prevention and Recovery
Medicaid Liaison
600 East Ash Street
Building 500, Third Floor North
Springfield, Illinois 62703

A copy of the completed adjustment will be returned to the provider with the Document Control Number of the adjustment made. 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.

Item 4 - Payee

Always enter 1.

Item 5 - Provider Reference (Optional)

Enter the participant'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 participant 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 participant's spenddown amount, enter 906.

Item 19 - TPL Amount

Enter the amount paid by the participant's insurance or, if the participant is subject to spenddown requirements, enter the spenddown amount the participant has paid or for which the participant 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 service due to incorrect or insufficient information. Review the billing instructions to determine proper field content and requirements.

ERROR	MESSAGE	PROCEDURE
C31	Procedure not on file for date	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 IDHS representative.
C32	Procedure illogical for category of service	Review procedure codes billed ensuring procedure codes listed are valid. If valid code was originally used, contact your IDHS representative.

"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.

ERROR	MESSAGE	PROCEDURE
D01	Duplicate payment voucher	An invoice was received which was a duplicate of one previously processed. If the claim was not previously paid, contact your IDHS representative.
D22	No claim found to be adjusted	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 IDHS representative.
D23	Duplicate adjustment found for this claim	A previous adjustment was submitted on the same original claim.
D97	Denied adjustment	Adjustment submitted is being denied. Contact your IDHS representative.

"G" SERIES – 180 DAY TIMELY FILING

New G55 edit regarding 180-day submittal timeframe. See 07/23/2012 and 03/22/2013 notices to all providers on HFS website.

ERROR	MESSAGE	PROCEDURE
G55	180 Day Timely Filing	IDHS and/or HFS will not consider for payment any claim received for charges more than 180 days from the date of service. If the service date is more than 180 days prior to HFS receipt of claim, the claim will be rejected.

"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.

ERROR	MESSAGE	PROCEDURE
P03	Provider not enrolled for category of service; date of service	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 after 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 IDHS representative.
P05	Provider number not on file	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 IDHS representative.
P06	Provider name does not match provider number	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.

"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.

ERROR	MESSAGE	PROCEDURE
R02	Participant name does not match participant number	The patient name and number does not match. Submit a new claim with correct information. Participant name and number must appear exactly as on MediPlan Card.
R03	Participant not eligible on date of service	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 participant number was used for dates of service being billed. Contact the local IDHS office for assistance. If the local IDHS 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 IDHS representative.
R06	Spenddown not met	Participant not eligible on date of service due to an unmet spenddown. 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.
R17	Service invalid for participant age	An invoice was received with a diagnosis, procedure, or revenue code denoting services, which are not covered for patient's age.
R36	Participant has part B Medicare	Bill needs to be submitted to Medicare for payment.
R66	QMB participant only-not eligible for Medicaid	On the date of service, the patient is a QMB participant and eligible for payment of Medicare co-insurance and deductible only. Provider should bill Medicare.