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Provider Bulletin H-200-11-01

Date: June 27, 2011

To: Participating Hospitals: Chief Executive Officers, Chief Financial Officers, Patient Accounts Managers; Renal Dialysis Providers; and Ambulatory Surgical Treatment Centers (ASTCs)

Re: Revisions to Billing Requirements for Reporting the Attending and Other Provider NPIs

Effective with all claims received August 1, 2011, and after, the department is implementing the following billing changes for provider identification:

- Form Locator 76 - Attending Provider Name and Identifiers. The Name and NPI of the attending provider will be required on all claims. Previously, the department did not require this field for outpatient renal dialysis (category of service 25).
- Form Locators 78 and 79 – Other Provider Names and Identifiers. Previously, the department had required these fields for outpatient renal dialysis and outpatient physical rehabilitation claims. These fields are situational. If a provider utilizes these fields, it must designate a two-digit Provider Type Qualifier Code in conjunction with the NPI.

These same reporting requirements apply to the X12 4010A1 837I claim transaction, Loop IDs 2310A and 2310C; upon implementation, the X12 5010 837I claim transaction, Loop IDs 2310A, 2310C, 2310D, and 2310F; and Direct Data Entry (DDE) – Physician Info Tab. The HIPAA 837I version [4010 and 5010 Companion Guides](#) are available on the department's Web site.

New Error Codes Associated with These Billing Requirements:

G33 – Missing/Invalid Qualifier. For UB-04 only. If there is an NPI entry in either FL 78 or 79 but the Provider Type Qualifier Code is missing or invalid, the claim will be rejected.

H45 – Missing/Invalid Other Operating Physician NPI. If the “ZZ” Other Operating Physician Qualifier Code is present, but the corresponding NPI is missing or invalid, the claim will be rejected.

H55 – Missing/Invalid Rendering Provider NPI. If the “82” Rendering Provider Type Qualifier Code is present, but the corresponding NPI is missing or invalid, the claim will be rejected.

H56 – Missing/Invalid Referring Provider NPI. If the “DN” Provider Type Qualifier Code for the Referring Provider is present, but the corresponding NPI is missing or invalid, the claim will be rejected.

Hospitals and renal dialysis providers should use the billing guidelines in the Handbook for Hospitals Services, Appendix H-2, **in conjunction** with the UB-04 Data Specifications Manual. To become a UB-04 Subscriber, refer to the [National Uniform Billing Committee \(NUBC\)](#) Web site.

Appendix H-2 in the [Handbook for Hospital Services](#) has been updated and is available on the department's Web site. Printed copies of this bulletin and replacement pages for the handbook are available upon written request. To ensure delivery, specify a physical street address when making a request for a paper copy. Submit your written request or fax to:

Illinois Department of Healthcare and Family Services

Provider Participation Unit

Post Office Box 19114

Springfield, Illinois 62794-9114

Fax Number (217) 557-8800

[Email the Provider Participation Unit](#)

ASTCs should use the information in this notice in conjunction with the [October 21, 2010 ASTC notice and billing guide](#) on the department's Web site. Form Locators 78 and 79 are conditionally required for claims for this provider type. This billing information will be incorporated into a revision of the Handbook for ASTCs.

Any questions regarding this bulletin should be directed to your facility's medical assistance consultant in the Bureau of Comprehensive Health Services at 1-877-782-5565.

Instructions for updating the Handbook for Hospital Services:

Remove Appendix pages H-2a (5/6, 7/8); H-2b (5/6, 7/8); and H-2c (5/6) and insert updated pages H-2a (5/6); H-2b (5/6); and H-2c (5/6) with effective date August 2011.

Completion	Form Locator	Form Locator Explanation and Instructions for Inpatient Claims
Conditionally Required	54A,B.	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
Required	56.	National Provider Identifier – Billing Provider Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	57.	Other (Billing) Provider Identifier Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.
Required	58.	Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.
Required	60.	Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do not use the Case Identification Number.
Conditionally Required	64.	Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	67.	Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8 th position shaded area. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.
Conditionally Required	67A-Q.	Other Diagnosis Codes Enter the specific ICD 9-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8 th position shaded area.

Completion	Form Locator	Form Locator Explanation and Instructions for Inpatient Claims
Required	69.	Admitting Diagnosis Code – Enter the specific ICD 9-CM code without the decimal.
Conditionally Required	72a-c.	External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
Conditionally Required	74.	Principal Procedure Code and Date - Required if a procedure is performed.
Conditionally Required	74a-e.	Other Procedure Codes and Dates – Required if there were any additional procedures performed.
= Required <i>Effective August 2011</i>	76.	Attending Provider Name and Identifiers For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.
=Conditionally Required <i>Effective August 2011</i>	77.	Operating Physician Name and Identifiers – Required if a surgical procedure is performed. For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI.
=Conditionally Required <i>Effective August 2011</i>	78-79.	Other Provider (Individual) Names and Identifiers – For claims received on and after October 1, 2008, the department will adjudicate claims based on the NPI. Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.
Required	81.	Code-Code Field – HFS Requirement (Needed for Adjudication) Qualifier “B3” – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300 , Handbook for Electronic Processing, available on the department’s Web site. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

Form Locator 80 Remarks – HFS utilizes this field to assign each claim’s unique Document Control Number. Providers do not utilize this field.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient, Outpatient Rehabilitation, and Outpatient Psychiatric Claims
Conditionally Required	54A,B.	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
Required	56.	National Provider Identifier – Billing Provider Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	57.	Other (Billing) Provider Identifier Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.
Required	58.	Insured's Name – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.
Required	60.	Insured's Unique Identifier (Recipient Identification Number) – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do not use the Case Identification Number.
Conditionally Required	64.	Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	67.	Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. The POA indicator is not required for outpatient claims.
Conditionally Required	67A-Q.	Other Diagnosis Codes - Enter the specific ICD 9-CM code without the decimal. The POA indicator is not required for outpatient claims.
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***Additional notes**

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Completion	Form Locator	Form Locator Explanation and Instructions for Renal Dialysis Outpatient Claims
Conditionally Required	54A-B.	Prior Payments – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
Required	56.	National Provider Identifier – Billing Provider Required for claims received as of May 23, 2008. The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	57.	Other (Billing) Provider Identifier Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. For claims received on or after May 23, 2008, the HFS legacy number will not be used for adjudication.
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Conditionally Required	64.	Document Control Number – At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	67.	Principal Diagnosis Code and Present on Admission (POA) Indicator - Enter the specific ICD 9-CM code without the decimal. The POA indicator is not required for renal dialysis claims.
Conditionally Required	67A-Q.	Other Diagnosis Codes - Enter the specific ICD 9-CM code without the decimal. The POA indicator is not required for renal dialysis claims.
Conditionally Required	72a-c.	External Cause of Injury (ECI) Code – The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

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