

August 2016

Hospital Billing Frequently Asked Questions

The instructions contained in this document are specific to patients enrolled in traditional fee-for-service or may have been enrolled in an Accountable Care Entity (ACE) or Care Coordination Entity (CCE). The instructions do not apply to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs).

Additional information for hospital providers is contained in the [Handbook for Hospital Services](#) on the Department's handbook webpage. Provider notices and bulletins are on the [Medical Providers Notices](#) webpage. Providers are encouraged to sign up for [email notification](#) to be alerted when new provider information is released.

1. My claim has not appeared in MEDI?

HFS assigns a document control number to a claim at the time it is entered into processing by the Department, whether the claim is paper or electronic. The Medical Electronic Data Interchange ([MEDI](#)) system is a reflection of the HFS processing system. If the provider cannot locate the claim in MEDI, HFS staff cannot either. Providers may resubmit their claims if their claims fail to appear in the MEDI System thirty (30) days after submission to the Department.

2. When calling a hospital billing consultant, what information do I need to have ready?

The provider should review their claim to determine if the denial reason was valid prior to calling a consultant. Please have your NPI or legacy HFS provider number; recipient number; date of service; and any rejection messages you have received.

3. What are the exceptions for mandatory concurrent review, error code A88?

- A participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted. **Note:** Medicare Part B only inpatient claims require review.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment at the time of admission.
- The patient remains unresponsive or has a physical or mental impairment during the hospitalization that prevents the hospital from identifying coverage under one of the Department's medical programs.
- Other – the hospital must provide narrative description.

Claims that relate to an exception must be submitted with an [HFS 1624A UB-04 Override Request form](#) that identifies the exception to the following address for manual review:

Illinois Department of Healthcare and Family Services
Bureau of Hospital and Provider Services
P.O. Box 19128
Springfield, Illinois 62794-9128

If the Department approves the request, the claim will suspend for retrospective prepayment review.

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4. Why is the claim rejecting for A88 when I have eQHealth approval and a treatment authorization number (TAN)?

The provider should verify that the admitting diagnosis code, length of stay and provider number matches the eQHealth approval notice. If the provider submitted any of these fields incorrectly, a new claim must be sent to the Department with the eQHealth approval notice.

5. When will we receive a payment?

HFS processes medical claims and the Office of the Comptroller issues the warrant. For payment information, please go to the [Comptroller's website](#). For voucher information, contact the Voucher Unit at HFS at 217-782-7149. If requesting a copy of a voucher, please have your HFS provider number and the voucher number available. Providers should wait at least 30 days from the date of the voucher to request a copy.

6. Why is my claim rejecting G67?

If the procedure is for back or coronary artery bypass graft (CABG) surgeries, it requires prior authorization from eQHealth. The exceptions to mandatory concurrent review still apply in this situation (see Question #4). If it meets one of the exceptions, the claim will need to be submitted on a paper UB-04 with an [HFS 1624A](#) requesting a G67 override.

7. What are HFS' timely filing requirements?

Timely filing is 180 days from the discharge date. Medicare/Medicaid combination claims are allowed 24 months from the date of service. If you have an exception to the 180 days filing limit, submit the claim on paper with an [HFS 1624A](#) override request form. Exceptions are identified in [89 Ill. Admin. Code Section 140.20](#).

8. When is a National Drug Code (NDC) required?

Effective with dates of service on and after July 1, 2014, hospitals are required to identify the NDCs in FL 43 for **all** outpatient drugs billed. Claims that do not contain a valid NDC will reject with an E07 error code.

9. Where would I find some billing examples and required fields for Medicaid?

Required fields for inpatient, outpatient, and renal dialysis claims, plus billing scenarios, are in Appendix H-2 of the [Handbook for Hospital Services](#).

10. How do I bill for observation services?

Hospitals and ASTCs are still required to code observation services with Revenue Code 0762 and an associated HCPCS Code as identified in the [Ambulatory Procedures Listing \(APL\)](#), and note the number of hours in observation in FL 46 – Service Units. Additionally, providers must code a second Revenue Code 0762 line and identify HCPCS code G0378 in order for observation services to process correctly. The minimum billable observation time is one hour.