

## Chapter 100 – General Policy and Procedures Appendices

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#### **Additional Resources for Providers**

- [TPL Code Directory \(pdf\)](#)
- [PBM-TPL Code Directory \(xls\)](#)
- [Error Codes \(xls\)](#)

**Issued September 2017**

## General Appendix 1

### Julian Date Calendar - Perpetual

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

## General Appendix 1

### Julian Date Calendar - Leap Years

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

## General Appendix 2

### Adjustments

An adjustment form is used to adjust an incorrect payment, which has been reported on [Form HFS 194-M-2, Remittance Advice](#). Adjustment forms cannot be used to adjust a:

- rejected service
- suspended claim
- claim still being processed by the Department

To correct information on a claim which is suspended or still being processed, the provider must wait for the claim to appear with its final disposition on a remittance advice. However, if a claim has been processed and the provider has a Document Control Number (DCN) and knows that the claim is pending rejection, a Void/Rebill transaction can be submitted electronically through the 837P. **Please note:** the Void/Rebill function **is not** available through the 837I at this time.

If an adjustment is denied the provider will receive a copy of the form indicating the reason for the denial. When the adjustment action is finalized, the action will be reported on a [Form HFS 194-M-2, Remittance Advice](#), under the heading "Adjustment".

There are three versions of adjustment forms, based on the type of service being adjusted. The three versions are:

- HFS 1410 - Pharmacy
- [HFS 2249](#) - Hospitals, UB-billers (hospices, renal dialysis centers and LTC facilities—see **Note** below)
- [HFS 2292](#) - NIPS Providers (non-institutional providers)

Forms HFS 2249 and HFS 2292 can be completed on-line and printed for mailing to the Department.

**Note:** For service periods on or after 12/01/2016, LTC facilities will submit a [Form HFS 2249 Adjustment \(Hospital\)](#) to the Department to void a previously adjudicated claim for LTC services. Detailed information on the void and rebill process for LTC facilities, including an example of a completed Form HFS 2249, can be found on the [Long Term Care Direct Billing Resources](#) webpage on the Department's website.

### Mailing Instructions

Before mailing adjustment forms, providers are encouraged to review all forms for completeness and accuracy. The Department supplies preaddressed envelopes (HFS 1416 Adjustments) upon request. Providers may use the on-line [Medical Forms Request](#) to order a supply of the HFS 1416 adjustment form envelopes. Completed adjustment forms should be mailed to:

Illinois Department of Healthcare and Family Services  
P.O. Box 19101  
Springfield, IL 62794-9101

### **Adjustment Form Preparation**

All adjustment forms should be either typewritten or legibly hand printed in ink. Any required item left blank may result in the adjustment form being returned to the provider for proper completion.

The following explanation and instructions for completion correspond with the numbered entry fields on the adjustment forms:

1. Document Control Number - Leave blank. This field will be completed by the Department.
2. Provider Name (and) Provider Address - Enter the provider's name and address as it appears on the Provider Information Sheet.
3. Provider Number (NIPS and Pharmacy) - Enter the provider's ID number exactly as it appears on the Provider Information sheet. Do not use any spaces, hyphens, etc.

PAYEE (Hospital/UB billers) - Enter the single digit number of the payee to which payment was made. Payees are coded numerically on the Provider Information Sheet.

4. Payee (NIPS, Pharmacy) - Enter the single digit number of the payee to which payment was made. Payees are coded numerically on the Provider Information Sheet.

Provider Number (Hospital/UB billers and LTC facilities) - Enter the provider's number exactly as it appears on the Provider Information sheet. Do not use any spaces, hyphens, etc.

5. Provider Reference (NIPS and Pharmacy) - Completion of this field is optional; however, the numerical and/or alphabetical characters (up to a maximum of 10) utilized in the provider's accounting system for identification purposes may be entered. If an entry is made in this field, the information will be reported back to the provider on a future remittance advice reporting the disposition of the adjustment.

Provider NPI Number (Hospital/UB billers) - Enter the provider's National Provider Identifier. The NPI (National Provider Identifier) is a federal Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique 10-digit identification number assigned to healthcare providers, payees, and health plans.

6. Voucher Number - Enter the eight digit identifier, which appears in the lower left corner of the remittance advice, which reported payment of the service.
7. Document Control No. (NIPS, Hospital/UB billers, Pharmacy and LTC facilities) - Enter the Document Control Number, which appears in the first column on the left of the remittance advice.
8. Serv. Sect. (NIPS and Pharmacy) - Enter the appropriate number to identify the specific Service Section to be adjusted. This number appears on the remittance advice in the first column on the left below the participant's name.  
  
COS (Hospital/UB billers) - Enter the appropriate Category of Service.
9. Date Of Service - Enter the date of service in the MMDDYY format as it appears on the remittance advice for the particular service/item to be adjusted.  
  
For hospital/UB billers, when adjusting claims for more than one day of service, enter the first paid date of service from the remittance advice.  
  
For NIPS adjustments a separate form is required for each date of service.  
  
For LTC facilities enter the claim begin date.
10. Item or Service (NIPS) - Enter the procedure code as it appears on the remittance advice.  
  
NDC (Pharmacy) - Enter the NDC for the item or the service to be adjusted as it appears on the remittance advice.  
  
Provider Reference Number (Hospital/UB billers) - Completion of this field is optional; however, the numerical and/or alphabetical characters (up to a maximum of 10) utilized in the provider's accounting system for identification purposes may be entered. If an entry is made in this field, the information will be reported back to the provider on a future remittance advice reporting the disposition of the adjustment.
11. Recipient Name (NIPS, Hospital/UB billers, Pharmacy and LTC facilities) - Enter the patient's name exactly as it appears on the remittance advice (first and last name).
12. Recipient Number (NIPS, Hospital/UB billers, Pharmacy and LTC facilities) - Enter the nine digit recipient number as it appears on the remittance advice.
13. Date of Birth (NIPS, Hospital/UB billers, Pharmacy) - Enter the patient's date of birth in the MMDDYY format as it appears on the remittance advice.

14. ADJ. Type or Reason Adjustment Requested - On all provider-initiated adjustments, one of the following codes must be entered to identify the reason the adjustment is being requested:
- 01 Third Party Collection - This code is to be used when payment is received for a claim from another source after payment was made by the Department. Repayment must be made to the Department of any amount received from another source up to the amount received from the Department.
  - 02 Billing or payment error on an individual Service Section detected by the provider or, for hospitals/UB billers, when a claim has been paid in error. This code is to be used when the provider determines:
    - Payment was made based on erroneous information entered in a Service Section of the claim such as an incorrect procedure code or charge.

**or**

    - A Service Section was paid in error, e.g., a duplicate payment, a payment made on behalf of a patient unknown to the provider, etc.
  - 03 Reconsideration - This code is to be used if the provider wants to ask that the Department review and determine whether special circumstances may permit a change in the amount paid for a specific service. **Note:** This adjustment type/reason adjustment requested code does not apply to hospitals/UB billers.
15. Item or Service (NIPS) - This field is used only when the original claim contained an error in the entry of the procedure code number by the provider, or when the remittance advice returned to the provider showed a procedure code number different from that originally submitted. Enter the procedure code which should have been reported.
- NDC (Pharmacy) - This field is used only when the original claim contained an error in the entry of the NDC number by the provider, or when the remittance advice returned to the provider showed a NDC number different from that originally submitted. Enter the NDC number which should have been reported.
- Provider Signature (Hospital/UB billers and LTC facilities) - After reading the certification, the provider or an authorized representative must sign the completed form. The individual must sign his or her own name. The signature must be handwritten black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned adjustment forms will not be accepted by the Department and will be returned to the provider.
16. Quantity (NIPS and Pharmacy) - Enter the correct quantity that should have been billed on the original claim.

Date (Hospital/UB billers and LTC facilities) - The date should reflect the date the adjustment form is signed. This entry may be either handwritten or typed.

### Department Action on Adjustments

When the Department receives an adjustment form initiated by a provider, a Document Control Number will be entered in box #1 of the form. This is a unique number used to identify the adjustment in the Department's files. Department staff will complete boxes 17 through 25 on hospital adjustments and boxes 23 through 37 on NIPS and pharmacy adjustments. An explanation of the Department's actions follows. The boxes completed by the Department are in bold.

17. Charges (NIPS and Pharmacy) - For Adjustment Type 01, enter the amount paid by the Department as shown on the remittance advice.

For Adjustment Type 02, when the reason for adjustment is a billing or payment error, enter the correct charge.

For Adjustment Type 03, enter the charges as it appears on the provider's copy of the claims.

**Process Type** (Hospital/UB billers) - Refer to description for field #23 for NIPS and Pharmacy.

18. TPL (NIPS and Pharmacy) - For Adjustment Type 01, enter the appropriate Third Party Liability code to identify the third party from whom payment was received. TPL information can be found when verifying eligibility on MEDI.

**CAT Service** (Hospital/UB billers) - A two-digit entry identifying the category of service under which the original payment was issued.

19. TPL Amount (NIPS and Pharmacy) - For Adjustment Type 01, enter the exact amount received from the third party payer. If the third party payment exceeds the Department's payment, enter the amount received from the Department. **Note that a line distinguishing cents has been pre-printed.**

When reporting an error in the original TPL amount, which appeared on the claim, enter the difference.

**Credit AMT** (Hospital/UB billers) - This is the total amount of credit due the Department as a result of the adjustment action. It may be possible to deduct the total credit from one voucher or it may be necessary to make a deduction from more than one voucher. When a check has been submitted, the amount of each paid service will be entered here.



20. Reason Adjustment Requested (NIPS and Pharmacy) - The provider must enter a clear and concise explanation of the reason the adjustment is being requested.

**Debit Amount** (Hospital/UB billers) - This is the additional payment amount approved by the Department as a result of the adjustment action.

21. Provider Signature (NIPS and Pharmacy) - After reading the certification, the provider or an authorized representative must sign the completed form. The individual must sign his or her own name. The signature must be handwritten black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned adjustment forms will not be accepted by the Department and will be returned to the provider.

**Reason Code** (Hospital/UB billers) - For Department record keeping only.

22. Date (NIPS and Pharmacy) - The date should reflect the date the adjustment form is signed. This entry may be either handwritten or typed.

**Reason Adjustment Made or Denied** (Hospital/UB billers) - This is a brief explanation of the Department's approval or denial of the adjustment.

23. **Process Type** (NIPS and Pharmacy) - This field identifies how the Department has processed the adjustment. It is a two digit number followed by either a "C" for Credit or a "D" for Debit. A credit signifies a deduction from the provider's payment unless the reason for the credit is a returned check. A debit signifies an addition to the provider's payment. The various process types are described below:

01C (Credit) TPL - This process type is created when the provider reports either:

- 1) the omission of TPL payment date on the original claim, e.g. when TPL payment was unknown at the time of billing, or
- 2) when a TPL payment or amount was incorrectly entered on the claim, e.g., \$10.00 instead of \$100.00.

When the process type is 01C, the credit amount will be automatically collected by the Department from future payments due the provider.

01D (Debit) TPL - This process type is used when the provider incorrectly entered the third party payment amount on the claim, for example, as \$100.00 instead of \$10.00. The debit amount will be added to a future payment due the provider from the Department.

03C (Credit) or 03D (Debit) - This process type is used when the Department has approved the provider's request for reconsideration.

05C (Credit Only) - This process type reports the receipt and processing of the provider's check submitted in response to findings of an audit conducted by the Department.

06C (Credit Only) - This process type represents a recoupment. Such credits will be collected by the Department from future payments due to the provider.

09C (Credit) - This process type is created by the Department when a separate adjustment has been processed to void a claim. Type 09C is necessary only when the voided claim has contained a debit adjustment. Because the Department only processes debit adjustments to valid paid claims, debit adjustments must be recouped when the original service is voided. Type 09C adjustments will be collected from future payments due the provider.

09D (Debit) - This process type is used when an additional payment is due the provider for a variety of reasons. The Department will provide an explanation by sending a copy of the adjustment form to the provider.

11C (Per Diem Mass to Detail Credit) - This process type is used when the Department is unable to decrease a provider's per diem or per visit rate prior to the effective date of a Department rate change. A date of service between the effective date of the rate change and the actual detail adjustment will be created for each service selected, when appropriate. Only the net Mass Amount of the adjustment is posted to the Payee Database.

11D (Per Diem Mass to Detail Debit) - This process type is used when the Department is unable to increase a provider's per diem or per visit rate prior to the effective date of a Department rate change. All dates of service between the effective date of the rate change and the actual date of the change will be automatically selected and adjusted. A detail adjustment will be created for each service selected, when appropriate.

12C (Financial Recovery Credit - Preliminary Fiscal Year Reconciliation Mass) - This process type is used to recoup overpayments based on a preliminary audit of the fiscal year cost report. The amount of the overpayment will be recouped from future payments. This adjustment is used to reconcile payments to providers paid on a per diem basis.

12D (Debit - Preliminary Fiscal Year Reconciliation Mass) - This process type makes a lump sum payment to a provider based on a preliminary audit of the fiscal year cost report. This adjustment is used to reconcile payments to providers paid on a per diem basis.

13C (Credit - Preliminary Fiscal Year Reconciliation Mass) - This process type is used to report the receipt of a provider's check, which serves as a year-end reconciliation. This adjustment is used to reconcile payment to providers paid on a per diem basis.

14C (Credit Only) - This process type is used when the provider submits a check representing payment by a third party source.

15C (Financial Recovery Credit - Final Mass) - This process type is used to recoup overpayments based on a final audit of the provider's fiscal year cost report. It may also be used to re-post an adjustment type 21C or to recoup a purged date of service. The amount of the overpayment will be recouped from future payments. This adjustment is used to reconcile payments to providers paid on a per diem basis.

15D (Debit Fiscal Year Reconciliation-Final Mass) - This process type makes a lump sum payment to a provider based upon a final audit of the provider's fiscal year cost report. This adjustment is used to reconcile payments to providers paid on per diem basis.

16C (Credit Only Fiscal Year Reconciliation-Final Mass) - This process type is used to report a receipt of a provider's check for overpayments based on a final audit of the provider's fiscal year cost report. This adjustment is used to reconcile payment to those providers paid on a per diem basis.

17C (Third Party Liability Credit) - This process type is initiated when a third party source payment is identified by the Department. The amount of the credit will be recouped from future payments to the provider.

17D (Third Party Liability Debit) - This process type is initiated when the Department determines a provider overstated the amount of TPL recovered on a service. The amount of the debit will be added to a future payment to the provider.

18C (Estimated Third Party Liability Credit) - This process type is used when, after the Department has made payment for a service, the provider determines that a third party payment source is available. The provider bills the TPL source and requests the Department payment amount be decreased by the estimated amount of the third party payment. The amount of the credit will be recovered from the future payments to the provider.

18D (Debit) - This process type is used when the provider estimated the amount of the TPL and upon adjudication of the claim the actual TPL amount was less than the estimated TPL amount. The debit will be the difference between the estimated TPL amount and the actual TPL amount. The amount of the debit will be added to a future payment to the provider.

19C (Credit Only) - This process type is used when the provider submits a check to void Department records of an individual service. This process type can also be used to void a service that paid at zero.

20C (Credit Only) - This process type is used when the provider submits a check for a portion of the Department's payment on a single service.

21C (Credit Only) - This process type is used when the Department records of an individual service are to be voided and the amount is to be recouped from future payments to the provider.

22C (Credit) - This process type signifies a recoupment for a single service. The amount of the credit will be recouped from future payments to the provider.

22D (Debit) - This process type signifies an additional payment for a single service. The amount of the debit will be added to a future payment to the provider.

25C (Credit Only) - This process type indicates the return by the provider of a debit the Department issued.

26C (Credit Only) - This process type indicates the recoupment of a debit the Department issued.

28C (Credit - NIPS and Pharmacy Only) - This process type is informational only. It confirms the receipt of a refund from the recipient's third party insurance company. No action is necessary.

32C (Credit Only) - This process type indicates the receipt of a refund check from the provider for purged services, voided services or services which cannot be identified.

**Employee** (Hospitals/UB billers) - A three digit number which designates either the Department employee or unit that completed the required data fields.

24. **CAT Service** (NIPS and Pharmacy) - A two digit entry identifying the category of service under which the original payment was issued.

**Date** (Hospital/UB billers) - The date on which the adjustment was reviewed. The format is MMDDYY.

25. **Credit Amount** (NIPS and Pharmacy) - This is the total amount of credit due the Department as a result of the adjustment action. (It may be possible to deduct the total credit from one voucher or it may be necessary to make a deduction from more than one voucher.) When a check has been submitted, the amount of each paid service will be shown here.

- Authorized HFS Signature** (Hospitals/UB billers) - The signature of the person completing the adjustment action.
26. **Debit Amount** (NIPS and Pharmacy Only) - This is the additional payment amount approved by the Department as a result of the adjustment action.
27. **CR %** - Credit Percent (Pharmacy) - This field is used when field 23 (Process Type) is 06C. This value represents the percent of each payment to the provider, which will be recovered and applied to the total amount of the credit.
- Error Code** (NIPS) - For Department record keeping only.
28. **Recoupment Begin Date** (Pharmacy) - Beginning service date for which recoupment (06C) may be applied.
- Reason Code** (NIPS) - For Department record keeping only.
29. **RECOUPMENT BEGIN DATE** (Pharmacy) - Beginning voucher date for which recoupment (06C) may be applied.
- REASON ADJUSTMENT MADE OR DENIED** (NIPS) - This is a brief explanation of the Department's approval or denial of the adjustment.
30. **OLD RATE** (Pharmacy) - For Department record keeping only.
- EMPLOYEE** (NIPS) - A three digit number which designates either the Department employee or unit that completed the required data fields.
31. **NEW RATE** (Pharmacy) - For Department record keeping only.
- DATE** (NIPS) - The date on which the adjustment was reviewed. The format is MMDDYY.
32. **ERROR CODE** (Pharmacy) - For Department record keeping only.
- AUTHORIZED HFS SIGNATURE** (NIPS) - The signature of the person completing the adjustment action.
33. **REASON CODE** (Pharmacy Only) - For Department record keeping only.
34. **REASON ADJUSTMENT MADE OR DENIED** (Pharmacy Only) - This is a brief explanation of the Department's approval or denial of the adjustment.
35. **EMPLOYEE** (Pharmacy Only) - A three digit number which designates either the Department employee or unit that completed the required data fields.

36. **DATE** (Pharmacy Only) - The date on which the adjustment was reviewed. The format is MMDDYY.
37. **AUTHORIZED HFS SIGNATURE** (Pharmacy Only) - The signature of the person completing the adjustment action.

## General Appendix 3

### Explanation of Remittance Advice Information

The remittance advice reports the status of claims (invoices) and adjustments processed. Following is an explanation of the information that appears on the form and a completed example of [Form HFS 194-M-2 Remittance Advice](#).

At the top of each page of the remittance advice, there are four labeled boxes:

**Provider Number** — This is the provider number exactly as it appears on the Provider Information Sheet.

**Type** — This is the Department code which identifies the type of provider for which the remittance advice is written.

**Date** — This is the date the remittance advice was created.

**Page** — Each page will be sequentially numbered. When several provider locations (Provider Numbers) are being paid to a central accounting address, page numbering will begin at 1 for each change of location.

**Note:** The information included in the body of the remittance advice is organized according to the type of actions described below. For provider types 30, 31 and 32, two major categories of “Reconcilable” and “Non-Reconcilable” may be printed in the center of the page preceding the type of action detail. This information is for Department use only.

#### Type of Actions

One or more of four different types of action may be reported on the same remittance advice. Actions reported will be grouped on the report based on the type of action taken. The type of action will be printed in the center of the page preceding the report of action taken. Within each of these action types, claims and adjustments will be reported in Document Control Number sequence.

Headings indicating the type of action appear on the remittance advice in the following order:

- **Adjudicated Invoices — Previously Suspended**

Claims listed in this group will have been reported on an earlier remittance advice as Suspended Invoices (Status Code SS). Adjudication of invoices reported under this heading has been completed and the final status code will appear for each invoice.

- **Adjudicated Invoices**

Claims listed in this group will include both invoices which are being paid and invoices being rejected and will include a report of action taken on the following types of invoices:

**For UB-04 Billers**

- Invoices which are being paid at the full amount billed.
- Invoices which are being paid at an amount less than the amount billed.
- Invoices for which no payment is being made. These will include:
  - Invoices containing errors
  - Invoices showing credits (Third Party payments) equal to or greater than the Department’s established rate
  - Invoices showing “Spendedown” amount equal to or greater than the Department’s established rate

**For Non-Institutional and Pharmacy Billers**

- Invoices on which all Service Sections are being paid.
- Invoices on which all Service Sections have been rejected.
- Invoices containing a mixture of paid, reduced and/or rejected Service Sections.

- **Suspended Invoices**

Claims in this group are being reviewed by the Department. For non-institutional claims, the entire invoice will be suspended when an error occurs in any Service Section. Final disposition on these claims will be reported on a future remittance advice as “Adjudicated Invoices - Previously Suspended.”

- **Adjustments**

This group reports any adjustments processed. For UB-04 billers, both approved and rejected late ancillary claims will appear in the adjustment section of the remittance advice.

**Note:** Provider-initiated adjustments which cannot be processed as submitted and cannot be corrected by Department staff (by means of written correspondence or a telephone contact with the provider) will be returned to the provider. These rejected adjustments will **not** appear on the remittance advice.



## Explanation of Data Elements

Data elements which appear in the unlabeled central areas of the sample remittance advices at the end of this appendix are identified by a circled number. This number corresponds with the item number in the following detailed explanation.

- ① **Document Control Number** - This is the unique number assigned by the Department to each invoice at the time it enters the payment processing system.
- ② **Prov Reference** - The provider reference number (up to 10 characters) is shown if one was entered on the invoice by the provider.
- ③ **Cat Serv (Hospital/LTC Facilities and UB Billers)** - The numeric code for the category of service that was billed will be printed in the third column of the remittance advice. All claims for the same category of service will be grouped together. The categories will appear in the sequence shown below although a remittance advice may not contain all categories of service.

20	Inpatient Hospital Services (General)
21	Inpatient Hospital Services (Psychiatric)
22	Inpatient Hospital Services (Physical Rehabilitation)
23	Inpatient Hospital Services (End Stage Renal Disease)
24	Outpatient Hospital Services (General)
25	Outpatient Hospital Services (End Stage Renal Disease)
26	General Clinic Services
27	Psychiatric Clinic Services (Type A)
28	Psychiatric Clinic Services (Type B)
29	Clinic Services (Physical Rehabilitation)
35	Subacute Alcoholism and other Drug Abuse
37	Skilled Care - Hospital Residing
38	Exceptional Care - Hospital Residing
39	DD/MI - Hospital Residing
60	Hospice
65	LTC Full Medicare
70	LTC Skilled
71	LTC Intermediate
72	LTC – NF Skilled (partial Medicare coverage)
73	LTC – ICF/MR
74	LTC – ICF/MR Skilled Pediatric
76	LTC – Specialized Living Center – Intermediate MR
82	LTC – Developmental Training (ICF/MR)
83	LTC – Developmental Training (ICF)
86	LTC SLF Dementia Care (Waivers)
87	LTC – Supportive Living Facility (Waivers)

**Recipient Name (NIPS and Pharmacy)** - This identifies the patient to whom the billed services were provided.

- ④ **Date of Service (Hospital/LTC Facilities and UB Billers)** - For inpatient services, the date appearing in the first line is the first day included in that particular claim. The date appearing in the second line is the last day included in that particular claim. For outpatient or clinic services, the date appearing in the first line is the actual date of service.

**Recipient Number (NIPS and Pharmacy)** - This field indicates the unique nine-digit number submitted on the claim for the patient.

- ⑤ **Amount Billed (Hospitals/LTC Facilities and UB Billers)** - This column reflects the amount of “Total Covered Charges” on the UB form or received 837I claim.  
**Note:** For Medicare crossover claims, the amount shown will be the deductible and/or coinsurance.

**Section (NIPS and Pharmacy)** - This entry identifies the Service Section being reported from the claim. A deleted section will not appear.

- ⑥ **Amount Allowed (Hospital/LTC Facilities and UB Billers)** - This is a multi-purpose column which will show one of the following:
- The amount of payment allowed by the department.
  - For late ancillary claims, this field will be blank because no payment is being made.
  - When a check or warrant has been returned to the department, this field will show the amount of the check or warrant.
  - For credit adjustments, this field will show the actual amount being recovered on the particular voucher.

**Cat Serv (NIPS and Pharmacy)** - this entry indicates the category of service for the service provided. Possible codes include:

01	Physician Services
02	Dental Services
03	Optometric Services
04	Podiatric Services
05	Chiropractic Services
10	Nursing Services
11	Physical Therapy
12	Occupational Therapy
13	Speech Therapy
14	Audiology Services
17	Anesthesia Services
18	Midwife Services
30	Healthy Kids

40	Pharmacy
41	Medical Equipment
43	Clinical Laboratory Services
44	Portable X-ray Services
45	Optical Supplies
48	Medical Supplies
50	Emergency Ambulance Transport
51	Non-emergency Ambulance Transport
52	Medicar Transport
54	Service Car
55	Private Auto
56	Other Transportation
57	Nurse Practitioner Services

- ⑦ **Status (Hospital/LTC Facilities and UB Billers)** - One of the following code entries will appear explaining the action taken on the net charge made: **PD** (paid); **RJ** (rejected - no payment); **SS** (suspended-action pending).

For each adjustment or late ancillary claim, this field will show one of the following codes: **DB** (debit); **CR** (credit); **RT** (check returned by the provider); **PS** (a processed credit adjustment for which no payable claims are available. When a **PS** is reported, the amount of the credit will be taken from a subsequent payment(s). The subsequent application of this credit will appear with the same Document Control Number and a status of CR.

**Date of Service (NIPS and Pharmacy)** - This entry is the date of service for the procedure/item reflected in the particular Service Section.

- ⑧ **Error Codes (Hospital/LTC Facilities and UB Billers)** - The remittance advice will report error codes to provide further information regarding the status of a claim or service. A three character code, one alpha character and two numeric characters, will appear to indicate the specific error which caused the action taken by the Department. A listing of [Error Codes](#) is available on the Department's website.

When the "Status" entry is RJ, an error code will be shown to identify the reason the claim was rejected. When the "Status" entry is SS, an error code will be shown to identify the reason the claim was suspended.

**NDC/ITEM OR SERVICE (NIPS and Pharmacy)** - This entry is the procedure code/item number as entered on the claim.

- ⑨ **Patient Name (Hospital/ LTC Facilities and UB Billers)** - This field identifies the patient to whom the billed services were provided.

**Note:** The words "Mass Adjustment" will be shown in this field when an [HFS 2249](#), hospital adjustment form is processed to correct several claims or for an adjustment not related to specific claims, for example, to report cost reconciliation.

**Important:** For LTC providers the HFS 2249 hospital adjustment form is only used to request a void of a single adjudicated and payable claim.

**Amount Billed (NIPS and Pharmacy)** - This entry is the provider charge from the claim.

- ⑩ **Recipient Number (Hospital/LTC Facilities and UB billers)** - This field indicates the unique nine digit number submitted on the claim for the patient.

**Amount Allowed (NIPS and Pharmacy)** - This entry is the amount of payment allowed by the Department. If the provider entered a TPL amount on the invoice, that amount was deducted by the Department when computing the allowed amount.

- ⑪ **NDC/Item or Service (Hospital/LTC Facilities and UB Billers)** - Based on the category of service, this field will show one of the following entries:

- **Days** followed by the applicable number of days which appeared on the UB claim form or the number of days computed by the Department based on the beginning and ending service dates.
- **Priced Using EAPG Grouper** for APL outpatient services.
- **LT ANC** is displayed in this field to reflect billing of late services and/or room and board charges.
- **ADJ** followed by the Process Type code reported in field 23 of the [HFS 2249](#) hospital adjustment form.

The Item or Service column is used to show any third party credit which appears on the invoice. The letters TPL will be followed by the three or four position code shown on the UB-04.

**STAT (NIPS and Pharmacy)** - This entry explains the action taken on the Service Section, using one of the following codes: PD (paid as billed); RD (paid at a reduced rate to conform with Department reimbursement policies; RJ (rejected, no payment); SS (suspended-action pending).

- ⑫ **Error Codes (NIPS and Pharmacy)** - The remittance advice will report error codes to provide further information regarding the status of a claim or service. A three character code, one alpha character and two numeric characters, will appear to indicate the specific error, which caused the action taken by the Department. A listing of [Error Codes](#) is available on the Department's website.

When the "Status" entry is RJ, an error code will be shown to identify the reason the claim was rejected. When the "Status" entry is SS, an error code will be shown to identify the reason the claim was suspended.

Whenever an error or correction is made which relates to the entire document, the error message and associated error code will appear on the same line as the DCN. Examples of this type of error would be F16 - "Provider Number has been corrected" or D03 - "Missing Provider Signature." All other error messages appear directly below the Service Section to which they apply.

### **Provider Summary**

The final summary, which includes all reported claims/service sections and adjustments, is titled Provider Summary. The summary lines appear in the following order:

- Total Billed - The total for all charges associated with services adjudicated (either paid or rejected) or suspended being reported on the remittance advice.
- Total Rejected - The total amount of charges for all rejected services reported on the remittance advice.
- Amount Reduced - The total amount of reductions taken from charges for services paid.
- Amount Suspended - The total amount of charges associated with all services reported as suspended on the remittance advice.
- Total TPL - The total amount of third party payments reported on the voucher.
- Total Credits - The total of all credit applications made against payments reported on the remittance advice.
- Total Debits - The total of all debits processed on the voucher.
- Payable Amount - The sum of the Amount Allowed for each category of service (Hospitals/UB billers) or Service Section (NIPS and Pharmacy).

- Returned Check - The sum of all adjustments from personal checks or returned warrants which were processed on the voucher.

**Hospitals/UB-billers:** A summary of payments will be reported for reconcilable and non-reconcilable payments. In addition, summaries may be reported which:

- combine reconcilable and non-reconcilable claims reported for each category of service
- combine all categories of service for individual locations
- combine all records on the remittance advice for all locations for the payee.

Adjustment amounts will not be included in the “Total Billed” amount. Credit and debit amounts will not be included in the “Payable Amount,” but will be used in calculating the remittance advice total.

**NIPS and Pharmacies:** When there is only one provider per voucher, only a Provider Summary will be reported. When there are multiple providers/locations on a voucher, there will be a Provider Summary for each provider and a “Payee Summary” at the end of the remittance advice summarizing the activity for all providers/locations on the voucher.

At the bottom of each page of all remittance advices, there are three labeled boxes as follows:

**Voucher Number** - This entry is the unique number assigned to the specific remittance advice. It consists of a four digit Julian date followed by a four position sequence number. The voucher number must be identified on any correspondence to the Department about data on the remittance advice.

**Provider Mailing Address** - The address is the pay-to address on the provider's current Provider Information Sheet. The sixteen digit number above the payee name is a control number used by the Comptroller.

**Remittance Total** - When the remittance advice consists of multiple pages, this entry appears only on the final page. The amount entered is the amount of the State Warrant (check) which is reported on the remittance advice. The amount of the Remittance Total will be equal to the Payable Amount plus Total Debits minus Total Credits.



### Reduced Facsimile of Form HFS 194-M-2 for Non-Institutional Providers and Pharmacies

PROVIDER NUMBER 0360000000	TYPE 10	ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES REMITTANCE ADVISE VENDOR COPY 1	DATE 05/02/17	PAGE 1				
DOCUMENT CONTROL NUMBER RECIPIENT NAME	PROV REFERENCE RECIPIENT NUMBER	CAT SERV	DATE OF SERVICE	NDC/ITEM OR SERVICE	AMOUNT BILLED	AMOUNT ALLOWED	STAT	ERROR CODES

ADJUSTED INVOICES

①	②	③	④	⑥	⑦	⑧	⑨	⑩	⑪	⑫
710701054321	776414									
JANE IMAGINARY	111111111	01	040517	37205	1603.00	935.00	RD	F01		
SECTION 01		PAYMENT REDUCED								
		TPL INFORMATION								
71070154322	776414									
JANE IMAGINARY	111111111	01	040517	54150	42.00		RJ	R16		
SECTION 02		SERVICES INVALID FOR RECIPEINT SEX								
		ADJUSTMENT INFORMATION								
PROVIDER SUMMARY										
							TOTALED BILLED	1645.00		
							TOTAL REJECTED	42.00		
							AMOUNT REDUCED	668.00		
							AMOUNT SPENDED			
							TOTAL TPL	0.00		
							TOTAL CREDITS			
							TOTAL DEBITS			
							PAYABLE AMOUNT	935.00		
							RETURNED CHECK			
IF REMITTANCE TOTAL IS LESS THAN \$1.00, NO PAYMENT IS MADE										

VOUCHER NUMBER

PLEASE REFER TO THIS NUMBER AND TO THE DOCUMENT CONTROL NUMBER ON ALL CORRESPONDENCE

1 OF 1

HFS 194-M-2 (R-4-91)

PROVIDER MAILING ADDRESS

0360000000011111111

REMITTANCE

TOTAL



## General Appendix 4

### Provider Forms Request Instructions

With the exception of UB claim forms, the Department provides required billing forms, prior approval requests forms, adjustment forms and various types of pre-addressed mailing envelopes to be used by providers when submitting claims and adjustments to the Department. Single sheet billing forms are intended for use only in laser printers. Multi-page continuous feed forms are intended for use in either typewriters or impact printers.

These materials may only be obtained by submitting [Form HFS 1517](#), Provider Forms Request, to the Department. Except for the HFS 1517 form, the Department will not mail forms in response to telephone requests.

Providers should submit the HFS 1517, Provider Forms Request at least three weeks in advance of needing the requested forms. HFS billing forms cannot be obtained from Department of Human Services' offices. Form HFS 1517 can be ordered online at [Medical Forms Request](#)

#### Preparation Instructions - Form HFS 1517, Provider Forms Request

Instructions for the completion of the form follow the order in which the entry fields appear on the form. The form should be either typewritten or legibly hand printed.

- **Provider Name, Provider Number, Provider Type and Address** - Enter the provider name, provider number and provider type exactly as they appear on the Provider Information Sheet received from the Department. Enter the name and address to which forms and envelopes are to be sent. Inclusion of the zip code is essential. Forms and mailing envelopes will be sent only to enrolled providers. HFS will not provide forms or envelopes to a billing service, unless the order includes the name and provider number of a currently enrolled medical provider on whose behalf the billing service is requesting forms.
- **HFS Form Number and Quantity** - Enter the HFS form number(s) being requested. Generally, the form number is shown in the lower left corner of the form. In most cases, the form number format will be "HFS" followed by a number or number/alpha combination. Enter the quantity of each form requested. The quantity should be in lots of 100, i.e., 100, 200, 500, etc. Please request a sufficient quantity to last three (3) months. If applicable, indicate whether the forms are to be Continuous Feed or Snap Out. Refer to the [Chapter 200](#) handbook for applicable form number(s) specific to the provider type or service.
- **HFS Envelope Number and Quantity** - Enter the HFS envelope number being requested. The envelope number is displayed in the lower left corner on the front of the envelope. Enter the quantity of envelopes being

requested. The quantity should be in lots of 25, i.e., 25, 50, 75, etc. Please request a sufficient quantity to last three (3) months. Refer to the [Chapter 200](#) handbook for applicable envelope number(s) specific to the provider type or service.

### **Mailing Instructions**

The original Form HFS 1517, Provider Forms Request, should be mailed to:

Illinois Department of Healthcare and Family Services  
Medical Desk, HFS Warehouse  
2946 Old Rochester Road  
Springfield, Illinois 62703-5659

Form HFS 1517 may also be submitted by fax at: 217-557-6800.

Updated September 2019

### General Appendix 5 Cost-Sharing for Participants

Service	All Kids Assist* 0%-147% (142% plus 5%)	All Kids Share* 148%-157%	All Kids Premium Level 1* 158%-209%	All Kids Premium Level 2* 210%-318% (313% plus 5%)	Moms and Babies/ Medicaid Presumptive Eligibility (MPE) 0%-209% (204% plus 5%)	Aid for the Aged, Blind or Disabled 0% - 100% (Resources - \$2,000 to \$3,000)	Health Benefits for Workers with Disabilities 100% - 350% (Resources to \$25,000)	Family Care and ACA Adults 0%-138% (133% plus 5%)	Breast and Cervical Cancer Program	Illinois Veterans Care
CPT Codes 99201 – 99215	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
CPT Codes 99241 – 99245	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
CPT Codes 90791 – 90911	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
CPT Codes 92002 – 92014	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
CPT Codes 98940 – 98943	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	Not Covered
T1015 (Medical or Dental Encounter)	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
T1015 (Behavioral Health Encounter)	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
Family Planning Services Billed with Modifier FP	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Restorative Dental Visits	\$0	\$3.90/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	\$0	\$0	\$0	\$15.00/visit
Prescription Drugs (Per 30-day supply)	\$0	Brand \$3.90 Generic \$2	Brand \$5 Generic \$3	Brand \$7 Generic \$3	\$0	\$0	\$0	\$0	\$0	Brand \$14 Generic \$6
Over-The Counter (OTC) Medications	\$0	\$2.00/drug	\$3.00/drug	Not covered	\$0	\$0	\$0	\$0	\$0	Not Covered
Emergency Room Visit	\$0	\$0	\$5.00/visit	\$30.00/visit	\$0	\$0	\$0	\$0	\$0	\$50.00/visit
Emergency Room Visit for Non-emergent Service	\$0	\$0	\$25.00/visit	\$30.00/visit	\$0	\$0	\$0	\$0	\$0	\$50.00/visit
Hospital Inpatient Services (Including substance abuse & mental health services)	\$0	\$3.90/day	\$5.00/day	\$100/ admission	\$0	\$0	\$0	\$0	\$0	\$150/ admission
Hospital Outpatient Services	\$0	\$3.90/visit	\$5.00/visit	5% of HFS rate	\$0	\$0	\$0	\$0	\$0	10% of HFS rate
Annual Copayment Maximum	\$0	\$100 per family	\$100 per family	\$500 per child	\$0	\$0	\$0	\$0	\$0	\$0

\*No co-payment for Well-Child, Immunizations, Preventive Services, Diagnostic Services or Family Planning. Family planning related medical services require a co-pay for office visits. Claims for well child and family planning visits must be submitted with modifiers "EP" (EPSDT) or "FP" (Family Planning).

Note: Copayments are exempt for services for which Medicare is the primary payer.

## General Appendix 6

### Vendor Category of Risk

As a result of [Public Act 097-0689](#), referred to as the Save Medicaid Access and Resources Together (SMART) Act, enrollment of a vendor in the Medical Assistance Program (Medicaid) is conditional for one year (305 ILCS 5/5-5). During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the Medicaid program without cause. Such termination or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

The Department is authorized to limit the conditional enrollment period for vendors based upon the risk of fraud, waste, and abuse that is posed by the category of risk of the vendor. The Department defines "high," "moderate," and "limited" vendor categories of risk as follows:

High Risk Vendor — Conditional enrollment period of one (1) year

- Transportation (ambulance, medicar, hospital-based, taxicab/livery company, or nonregistered, but excluding private auto)
- Durable Medical Equipment Supplier
- Home health

Moderate Risk Vendor — Conditional enrollment period of one (1) year

- Hospice
- Imaging Center
- Independent Laboratory
- Physical Therapist
- Alcohol and Substance Abuse Provider

Limited Risk Vendor — Conditional enrollment period of nine (9) months

- All vendors that are not defined as either "high" or "moderate" risk

#### Adjustment in the Category of Risk of a Vendor

The Department may adjust the category of risk level of a specific vendor from "high" or "moderate" risk to "low" risk if, within one (1) year of the date of submission of the vendor's application for enrollment in Medicaid, the vendor has been:

- certified or accredited by Medicare
- issued a CLIA Certificate
- enrolled in good standing in the Medicaid program of a state that borders Illinois

The Department will adjust the category of risk level of a specific vendor from "low" or "moderate" risk to "high" risk if any of the following occur:

- The vendor\* has been excluded, denied, suspended, terminated, debarred from, or otherwise sanctioned by Medicaid, Medicare, or any other federal or state healthcare program.
- The vendor\* has a delinquent debt owed to the Department.
- At any time during the last 10 years, the vendor\* has:
  - been subject to payment suspension by the Department.
  - been precluded from billing Medicaid, Medicare, or any other federal or state healthcare program.
  - had billing privileges revoked by Medicare.
  - been subject to suspension or revocation of a license to provide healthcare by Illinois or any other state's professional licensing authority.
  - been subject to revocation or suspension by an accreditation organization.
  - been convicted of an offense defined in 305 ILCS 5/12-4.25(A-10).

During the conditional enrollment period, vendors are subject to enhanced Department oversight, screening, and review based on the category of risk of the vendor.

<b>Type of Oversight, Screening, and Review</b>	<b>Limited Risk Vendor</b>	<b>Moderate Risk Vendor</b>	<b>High Risk Vendor</b>
<b>License/certification/authorization verification</b>	X	X	X
<b>Database checks</b>	X	X	X
<b>Prepayment audit review</b>	X	X	X
<b>Audit</b>	X	X	X
<b>Payment cap</b>	X	X	X
<b>Payment suspension</b>	X	X	X
<b>Unscheduled/unannounced site visit</b>		X	X
<b>Criminal background check**</b>			X
<b>Financial background check**</b>			X
<b>Fingerprinting**</b>			X

The Department is authorized to use additional means of oversight, screening, and review, including as required by federal and state law.

\* The vendor or a person with management responsibility for the vendor; an officer of the vendor; a person owning, either directly or indirectly, 5 percent or greater of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship that is a vendor; or a partner in a partnership that is a vendor.

\*\* For all corporate vendors categorized as "high risk," screening activities apply to any person owning, either directly or indirectly, 5 percent or greater of the shares of stock or other evidences of ownership in the vendor. For transportation vendors categorized as "high risk," screening activities additionally apply to managers and dispatchers. For individual vendors categorized as "high risk," screening activities apply to the individual.

## General Appendix 7

### Self-Disclosure Protocol

The mission of the Department's Office of Inspector General (the OIG) is to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct in the Medical Assistance (Medicaid) program. As part of the multi-disciplinary approach to attaining these goals, the OIG supports health care providers and vendors (providers) who voluntarily self-refer to the provider disclosure protocol upon detection of a violation of Medicaid program requirements resulting in an overpayment from the Department.

The federal Patient Protection and Affordable Care Act (ACA), requires providers to timely identify and repay Medicaid overpayments. Under the ACA, providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. (See 42 U.S.C.A. Section 1320a-7 k (d)). Providers failing to disclose, explain, and repay the overpayment in a timely manner may be subject to liability under the federal False Claims Acts, among other penalties.

While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, it is essential to develop and maintain a fair, reasonable, and consistent process that will be mutually beneficial for both the Department and the provider involved. In order to encourage providers to utilize the self-disclosure protocol, the OIG offers incentives for providers to investigate and report matters that involve possible fraud, waste, abuse, mismanagement, or misconduct—whether intentional or unintentional—under the Medicaid program. By forming a partnership with providers through this self-disclosure approach, the OIG's mission will be enhanced, while simultaneously offering providers a mechanism that may reduce their legal and financial exposure.

The OIG recognizes that the situations that are appropriate for referral to the self-disclosure protocol could vary significantly; therefore, this protocol is written in general terms to allow providers and the OIG the flexibility to address the unique aspects of the matters disclosed.

#### Advantages of Self-Disclosure

Self-disclosure of overpayments will, in most circumstances, result in a better outcome for a provider than if the OIG discovered the matter independently. While the specific resolution of a self-disclosed matter depends upon the individual merits of the case, the OIG typically extends the following benefits to providers who participate in a self-disclosure in good faith:

- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of some or all applicable penalties and/or sanctions
- Timely resolution of the overpayment

- Decreased likelihood of imposition of an OIG Corporate Integrity Agreement (CIA)
- If made within 60 days of identification, avoidance of False Claims Act penalties.

Developing a partnership with the OIG during the self-disclosure process may also lead to a better understanding of the OIG's audit and investigatory processes, benefitting the provider in the future.

### **Determining if Self-Disclosure is Appropriate**

Providers should utilize the self-disclosure protocol after the provider fully investigates and confirms that an overpayment exists, or that billings were submitted erroneously even if no overpayment occurred. In addition, providers must be mindful that 42 U.S.C.A. Section 1320a-7k(d)(2) requires a provider to self-disclose an overpayment within 60 days of the overpayment being identified or the date that any corresponding cost report is due, if applicable. Failure to report the overpayment in a timely manner subjects the overpayment claims to False Claims Act penalties (\$5,500 to \$11,000 per claim plus three times the amount of damages). However, because of the wide variance in the nature, amount, and frequency of overpayments that may occur, coupled with a wide variety of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Due to the complexity of some issues surrounding self-disclosures, providers may want to obtain the advice of an experienced health care legal counsel or consultant.

Issues appropriate for self-disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of state and federal laws relating to the Medicaid program, such as non-compliance pertaining to documentation and records, quality of care, cost reports, and third party liability.

The protocol is not intended to be used for minor or insignificant matters such as the repayment of simple occurrences of overpayment(s). Repayment of simple overpayments should typically be handled through traditional resolution methods such as voiding or adjusting the amounts of claims. The OIG encourages providers to utilize the self-disclosure protocol when circumstances warrant.

### **The Disclosure Process**

Once a provider determines that disclosure to the OIG is appropriate, the provider should prepare a written Disclosure Report with the following information, as applicable.



1. Provider information, including name (include doing business as name, or first, middle and last name as name), Medicaid provider identification number, license number, NPI, DEA number, business address, mailing address, telephone number, fax number, and e-mail address.
2. Contact person, if not the provider, and contact information. Specify the relationship of the contact person to the provider.
3. The basis (or bases) for the self-disclosure, including the approximate dates of service covered, the Medicaid recipient identification numbers if available, applicable procedure and/or diagnosis codes affected if applicable, and an assessment of the potential financial impact.
4. Citations to the specific state and federal Medicaid program laws, regulations, rules, policies, guidance, Handbook provisions, and/or other authorities that are or may be implicated.
5. A password protected or otherwise secure Excel or MS Access file with a detailed list of claims paid or submitted that comprise the overpayments. Each claim should list the Medicaid provider identification number, recipient name, Recipient Identification Number (RIN), date(s) of service, procedure code(s) billed, and the amount(s) paid by the Department. For identification purposes, the file/s must be named in accordance with the following format:  
NPI Number\_SelfD\_SubmittingDate.extension (xls/xlsx/mdb)  
Examples: 1234567890\_SelfD\_01012013.xls or xlsx (Excel) **or**  
1234567890\_SelfD\_01012013.mdb (MS Access)
6. Any law enforcement, state, and/or federal agency that has been notified of the same conduct. Include the name, title and contact information of notified individuals and the date of notification.
7. The nature and extent of any investigation or audit conducted by the provider to identify and determine the amount of the overpayment.
8. A summary of the identified underlying cause of the issue(s) involved and any corrective action taken, the date the correction occurred, and the process for monitoring the issue to prevent reoccurrence.
9. The names of individuals involved in any suspected improper or illegal conduct and whether they are still employed by, or otherwise affiliated with, the provider.
10. An attestation of accuracy and completeness of the Disclosure Report, signed by the provider (if an individual) or an authorized individual (if an organization).

The Disclosure Report (including the password protected or otherwise secure Excel or MS Access File) must be submitted electronically to the following email address:  
[HFS.OIG.SelfDisclosure@illinois.gov](mailto:HFS.OIG.SelfDisclosure@illinois.gov)

The Office of Inspector General will acknowledge receipt of each Self-Disclosure via return email and will contact the appropriate contact person with any questions and/or concerns.

No disclosure is complete until the Department receives a complete Self-Disclosure Report.

### **Assessment of Disclosures**

The OIG will consider each disclosed incident on an individual basis. In considering how a disclosure will be brought to conclusion, factors that the OIG will consider include, but are not limited to:

- The exact issue(s)
- The dollar amount involved
- The percentage of provider's overall Medicaid reimbursement involved
- Any patterns or trends
- The period of non-compliance
- Timely use of the self-disclosure protocol
- The circumstances that led to the non-compliance
- The provider's history with the Department, including recurring overpayments for the same reason
- Whether the provider has a CIA in place

Upon review of the provider's disclosure, the OIG may independently conclude that the matter warrants referral to the Illinois Attorney General's Medicaid Fraud Control Unit (MFCU) and/or other authorities. Alternatively, the provider may request the participation of a representative of the MFCU, Department of Health and Human Services Office of Inspector General, the Department of Justice, or a local United States Attorney's Office.

Upon review of the provider's disclosure, the OIG will consult with the provider and determine the most appropriate process for proceeding. The OIG expects the provider to cooperate fully, timely and in good-faith throughout the process. The OIG may request additional information or documentation. The OIG recommends that providers submit all requested and relevant information initially, to lessen the likelihood that additional information will be requested. Assuming that the provider cooperates, the OIG expects that self-disclosures will be handled in a timely manner.

The OIG will consider the provider's full, timely, and good-faith cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the OIG cannot reach agreement on the amount of the overpayment, or if a provider fails to cooperate in good-faith, the OIG may pursue the matter through established audit or investigation processes, and the possible advantages of self-disclosure, such as less stringent repayment and/or sanction terms, may no longer apply. Assuming the provider acts in good-faith, the mere fact that the provider and the OIG are unable to agree on a

repayment amount will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and the OIG are able to agree.

### **Relation to Ongoing Audits**

Matters related to an ongoing Department audit of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an ongoing audit may be eligible for processing under the protocol. If the OIG is already auditing or investigating the provider, and the provider wishes to avail themselves of the protocol, the provider should bring the matter to the attention of the assigned auditor and make a submission under the protocol. If an outside agency is auditing or investigating the provider for the conduct, and the provider seeks to disclose an issue to the OIG, the provider should follow this guidance accordingly.

### **Access to Information**

Providers are expected to promptly comply with OIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OIG also expects the provider to execute and provide business record certifications, whenever requested, in a form acceptable to the OIG.

The OIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. A provider's cooperation will be measured by the extent to which a provider (or provider's counsel) discloses relevant facts and evidence, not its waiver of privilege or protection. However, a lack of information may make it difficult for the OIG to determine the nature and extent of the conduct which caused the overpayment.

### **Restitution**

All provider self-disclosures are subject to independent OIG review and verification, including determining whether the overpayment amount identified by the provider is accurate. While repayment is accepted throughout the self-disclosure process and repayments will be credited toward the final settlement amount, the OIG will not accept any payment for self-disclosures as full and final payment prior to finalizing its review and verification process.

Once a repayment amount has been agreed upon between the OIG and the provider, the OIG expects the provider to reimburse the State of Illinois for the overpayment with payment in full or to enter into a repayment agreement if repayment was not previously made.

Upon closure of a matter, the OIG will issue settlement documentation.