

## **New Monthly Billing Process for Long Term Care Services Frequently Asked Questions**

### **Communication/Training**

- Q. Will there be a provider line to help correct claims and help with problems with claims not processing?**
- A. Yes, the staff currently assisting with LTC billing issues will continue to be the contact for LTC claim assistance. They can be reached at 217-782-0545 or via email at [HFS.LTC@illinois.gov](mailto:HFS.LTC@illinois.gov).

### **Claim Submittal Process**

- Q. Will HFS have an option in MEDI to allow the direct entry of each claim individually similar to Medicare's FISS system?**
- A. Yes, the IEC process is already established for other providers and can be reviewed in MEDI. Coding specific to LTC services will be provided. Direct Data Entry (DDE) has been updated for LTC claims entry, but will not accept claims for services prior to 10/1/2016. For providers billing a large number of recipients, it is recommended that the batch file submission of claims be utilized to submit claims.
- Q. Will providers be able to upload billing from accounting software programs? If so, when will testing be available?**
- A. Yes, depending on the software being used. The software must be able to produce an 837I claim in X12 format. Regarding testing, providers wishing to submit a test file may do so by utilizing the file Upload function in the IEC link in MEDI.
- Q. Will IEC and LTC links be available before 8AM, after 5PM and on weekends?**
- A. The MEDI IEC link is available 24/7, with the exception of small windows of time where the system is down for normal maintenance (downtime is minimal). The LTC links in MEDI, which are used to submit admission, discharge, TPL and income changes, are only available from 8 am-5 pm on state business days and cannot be extended beyond those hours.
- Q. Which Internet Explorer Browser is compatible?**
- A. IE 6 and later works with the MEDI/LTCEDI web application.
- Q. Is Medi able to handle the volume of Concurrent Users when LTC providers are on board?**

- A. Medi is designed to handle a large volume of concurrent users. At this point the Department does not believe that adding the LTC providers into the Medi DDE process will create any problems.
- Q. What is the Length of time that a user can be logged into DDE and not making entries before Medi will Time out?**
- A. Medi direct data entry has an automatic time out if the data entry session is idle for 20 minutes. More clearly, if a person is logged into Medi and entering a claim, but did not complete (submit) a claim within a 20 minute period, the session would time out.
- Q. Is there a capability to test Direct Data Entry in Medi?**
- A. There is not a Direct Data Entry test environment available for providers.
- Q. Is there a way to submit a test 837I file in a batch mode?**
- A. Yes, there is a way to submit a test file by uploading a test file via Medi. Note that a test file must contain a T in ISA-15 field in the 837I transaction. Submitter must also notify HFS that the test file has been submitted so that it can be intercepted and ran through the test environment. Instructions for submitting a test file is available on [Long Term Care Direct Billing](#) page of the HFS website.
- Q. When a provider is sending in an 837 Institutional claim file through the Medi upload process, can multiple claims for multiple providers be included?**
- A. Yes, but the site that will be billing for all of the providers must be configured in Medi to be allowed to submit for the other providers. This is done through the registration process.
- Q. If a file consisting of multiple claims contains one claim that is incorrect will the whole file be rejected or just the incorrect claim?**
- A. It depends on the packaging of the file. If all claims are enveloped with one Transaction Set Header (ST) and Transaction Set Trailer (SE) then the whole file would be rejected. If each claim within the submitted file has its own ST and SE then only the incorrect claim will be rejected.
- Q. Will Supportive Living Program claims use the 837I or the 1500 currently being used to bill MCOs?**
- A. SLP's will be using the 837I claim to bill services.
- Q. How will the State process claims for service periods prior to October 1, 2016 services?**

- A. Any admission prior to 07/01/2016 will have claims auto generated for services through 9/30/2016. Claims for services provided 10/01/2016 and after will be submitted by the provider.
- Q. Since HFS will not accept paper UB04's, will HFS allow providers to batch bill through their (or an approved) Network service vendor? Or can it only be done via the IEC option in MEDI?**
- A. Both options will be supported. Providers can go through a vendor/clearinghouse or claims can be submitted directly from the provider through the IEC links in MEDI. Direct data entry is also an option.
- Q. Do facilities/providers bill separately for ancillary charges or are they all included in the Room and Board charges?**
- A. The Medicaid per diem covers ancillaries, as well as room and board. HFS will accept ancillary revenue codes and charges submitted on claim but the Medicaid pricing of claim will only be based on the accommodation revenue codes that have been identified by HFS.
- Q. Should ancillary charges be billed as a separate claim for day of discharge if the discharge (not death related) falls on the first of the month?**
- A. No, HFS will not price or pay ancillary services for long term care providers so you would not need to submit a claim for these charges separately or at all.
- Q. Is there a limit on the number of files a provider can submit in one upload?**
- A. There is no limit on the number of files a provider can submit or upload. However, providers should keep track of the responses to make sure their file loaded successfully. Sometimes long transmissions will terminate early and a file will be incomplete.

### **Updating or Changing Recipient Information**

- Q. If an individual transfers from Home #1, to Home #2, and Home #2 enters the individuals into MEDI, Home #1 cannot access or review info regarding the individual. No corrections can be made by Home #1.**
- A. Home #1 should still be able to log into MEDI and have functionality for the dates of service that the individual was a resident of the home. If a provider is having issues, they should check their registration.
- Q. How will this affect the processes completed by the DHS caseworkers? (Changes in Income, Admissions, Re-admissions, Discharges, Patient Credit Calculations)**

A. Caseworker processes are not affected by the change in billing systems. In addition, the application of the timely filing of recipient status changes, such as admit and discharge information, will not change.

**Q. Do Income changes still have to be reported through the MEDI LTC link or can it be reported as a deduction on submitted claim?**

A. Changes in income must still be reported to DHS caseworker by submitting an income change transaction through the MEDI LTC link. The amount of patient credit should also be reported on the submitted claim using a Value Code of 23. However, the amount HFS will use to price the claim will be the amount approved and entered into the HFS system by the DHS caseworker. A claim will not reject if the amount reported with Value Code 23 on the claim is different from the amount in the HFS system.

#### **Claim Correction and Adjustment:**

**Q. The notice states we have to void claims for personal portion adjustments and wait for the void to be processed before we can rebill. This seems very inefficient.**

A. Since the system currently cannot process an electronic void/rebill, we are bound by the paper process for voids. Only claims that need to be corrected for reported covered days will require a void. The Department will automatically adjust claims for rate and patient credit changes.

**Q. How will “rejections” be reported and will it be timely?**

A. Rejections are reported once per week on a remittance.

**Q. After October 1, 2016, how will providers correct or amend any claims with issues prior to those dates?**

A. For services prior to October 1, 2016, corrections will follow the process that is currently in place. Adjustments to those claims will continue to be auto generated by the Department.

**Q. What will be the timely filing expectation for claim submission?**

A. 180 days from the date of service or completed admit transaction.

**Q. When/if income change is made; do we resubmit corrected bills/claims?**

A. The Department is developing an adjustment process to re-price claims for retroactive rate adjustments and patient credit (income) changes.

**Q. HFS 2249 – is not currently used. Info submitted via MEDI.**

A. This is correct, but since the Department will not be generating claims in the future, an HFS 2249 will be required to void a claim. Once the void is processed, the provider will be able to rebill the claim.

**Q. Nursing Homes report bed reserve, but don't get reimbursement.**

A. For service periods after 9/30/2016, providers will be required to provide leaves of absence (bed reserves) on the claim form, rather than submitting via MEDI.

**Claim Coding Questions:**

**Q. How do we report paid/unpaid bed holds?**

A. For service dates beginning October 1, 2016, all bed holds (Leaves of Absence) should be reported on the institutional claim record with an occurrence span 74 along with the dates. In addition, a total of all days should be reported as a revenue line with revenue code 182 – patient convenience, 183 – Therapeutic or 185 – Hospital Leave. Revenue code 182 and 183 will both be considered Therapeutic Leaves.

Any bed reserve for dates of service prior to October 1, 2016 should continue to be reported by entering a Bed Reserve transaction through the MEDI LTC link.

**Q. Do leave of absences have to be included in a claim for the whole month or can multiple claims be submitted for only the days in the month the resident was in the facility?**

A. One claim for the whole month with the leave of absences reported is preferable. However, multiple claims may be submitted for a month as long as the same day is not billed more than once. ICF/IID facilities and Supportive Living Providers must bill leave of absence days in order to receive payment for them.

**Q. Who is required to submit a RUG on the claim?**

A. Any facility can submit a RUG score but it will not be required at this time. Providers wishing to submit a RUG score may do so by using a revenue code 0022 showing the RUG Score in the Procedure Code field, the number of days in the units, zero charges on the revenue line, and a corresponding assessment date as an Occurrence code of 50.

**Q. How will we report to the State when someone is on Medicare/Insurance?**

A. If someone is Medicare primary, the claim should cross over from the Medicare COBC. If the claim does not cross over, the provider should bill Medicaid. Other Insurance primary claims should be billed to the other insurer and then the balance should be billed to the Department. These items are handled through a prior payer loop.

- Q. We have multiple facilities under the same TAX ID number that would be submitted on the claims, how will the State know the difference? (Currently the State puts a code on the end of each one for them to recognize the difference)**
- A. HFS will use our NPI crosswalk table to uniquely identify the facility. It is recommended that there be a 1 to 1 relationship between the facility's NPI and the legacy provider ID. If there is not a unique NPI for each provider number (including the 3 digit extension at the end), the NPI will not crosswalk correctly and will produce errors.
- Q. Can I use the same NPI to bill my Long Term Care claim as well as my Durable Medical Equipment/Oxygen/Transportation services?**
- A. The Department highly recommends that each provider type that will be billed should have a unique NPI.
- Q. What will happen if there is a claim submitted to Medicare with one name or spelling and that claim is then sent to Medicaid electronically from Medicare? Will the system reject the claim with a name mismatch?**
- A. There are certain edits that are relaxed when claims are coming in from Medicare. The patient name match is only applied to the claim when it is submitted from a provider. If the claim comes in from Medicare, this edit will not apply.
- Q. If caseworker doesn't have admission completed and entered, do we still submit claims?**
- A. No, if there is not an approved admission on the system, a claim for services will reject.
- Q. If we wait until the caseworker enters the admission, will the claims be denied as untimely?**
- A. Providers will have 180 days from the date the admission is placed on the system to submit claims for services provided prior to that date
- Q. If a Medicare crossover claim is received for a Recipient and HFS does not know the recipient had Medicare, will the claim reject?**
- A. No, the Department will take in the claim from Medicare and pay or reject accordingly. The biggest issue that will present is that the admission must be on file with the Department when the Medicare Crossover claim is received or the claim will reject.
- Q. If the recipient has Third Party Liability on the recipient database and there are no long term care benefits, is the primary payer on the claim still required to be the third party administrator?**

- A. No. HFS previously indicated that if Department records showed a recipient to have commercial insurance coverage, the Third Party Liability (TPL) payment information must be reported on the claim. Because LTC services are often not covered by insurance plans, HFS has determined that TPL payment information will not be required to be reported on the claim.

However, HFS will still allow TPL payments to be reported as a reduction from payable charges when submitted on the LTC claim in the “Other Payer” loop. The Department will also continue to seek collection of non-reported TPL payments through the current collection process.

**Q. When a recipient has Medicare Part A coverage do I need to wait to submit a claim to Medicaid until Medicare pays?**

- A. Services for recipients with traditional Medicare Part A coverage must be billed to Medicare prior to billing Medicaid. Claims submitted to Medicare will crossover to Medicaid through a fiscal intermediary. However, in the event that a Medicare claim is not successfully crossed over for Medicaid pricing, the provider should submit the claim with Medicare coverage directly to Illinois Medicaid for payment consideration only after Medicare’s adjudication.

**Q. What is the Payer Identifier required in NM109 of the 1000B loop of the 837I claim?**

- A. Claims submitted to Medicaid directly from provider should reflect Medicaid as the payer using the Medicaid identification number of 37-1320188 in loop 1000B. Clearinghouses may require providers to use a different number to identify Medicaid in their systems but claims submitted to HFS must use 37-1320188.

**Q. If claim sent to Medicare is only for the Medicare covered period of a month, do I need to send a separate claim for the Medicaid portion of the month?**

- A. Yes, if the Medicare crossover claim’s statement period is only for the Medicare covered days, then a separate claim can be sent directly to HFS for the Medicaid covered service days. The Medicaid claim should show a Bill frequency code of 1 or 2 and a Value code of A2 showing the first day of Medicaid coverage.

**Payment Reporting**

**Q. Will we get a status report each time we bill – accepted, in process, acknowledged?**

- A. Each electronic file submitted will be responded to with the appropriate HIPAA 999 transaction. Response files can then be picked up through our MEDI portal. Additionally if a claim is submitted via MEDI DDE, a corresponding confirmation report can be printed.

**Q. What is the relationship between the time that a file is uploaded, or a claim being entered, and the DCN date that will be on the claim?**

A. DCN date is critical for timely filing requirements. If a claim is sent in on a file or entered in Medi Direct Data Entry, there is a cut off time that is used to establish the DCN date on the claim. Records in the Medi System prior to 5:00 p.m. will be batch uploaded to the MMIS system and will receive a DCN date that is the current system date. All claims received in the system after 5:00 p.m. will receive a DCN the following day.

**Q. What will remittances look like and can Management Companies get copies?**

A. Proprietary remittances will be formatted and mailed, to the payee address on file with the Department, the same as they are today. Payees can also register to view remittances through IEC in an 835 format.

**Q. Will payments be issued on a monthly basis?**

A. The Department creates vouchers for payment and submits to the Comptroller. The timing of the payment is dependent on whether a provider is expedited and what other competing payment priorities are at the Comptroller's Office.

Regarding the HFS processing, the only difference will be when claims are entered into MMIS. Currently, claims are entered uniformly once per month. Under the new system, the process will be dependent on the billing practices of each provider.

**Q. How will payments be listed on the Vendor Website? Will the same DCN tracking be implemented?**

A. There is no change to the Comptroller's Vendor portal for this new billing process.

**Q. Since providers have in the past relied heavily on the pre-payment report for many uses (tracking residents who are now accepted for coverage/dropped from coverage) is there anything that is going to be replacing it? If not then what advice are they prepared to give to facilities? Is it simply waiting for the payment detail and working issues from that? Or using MEDI/REV to monitor each resident on a monthly basis for eligibility and payment?**

A. We recommend that LTC facilities utilize a 276/277 claim status inquiry and response. MEDI also can allow providers to do this inquiry and response on demand. In addition, the Department is developing a "Patient Roster" report that will provide a summary listing of individuals approved for payment and their enrollment status in managed care.

**Q. Will claims be paid in a timelier manner once processed?**

The new billing process will not impact the timing of payment.

**Q. Will payments come individually or on a remittance of claims submitted?**

- A. Remittances will group claims based on DCN date, payee and Department scheduling parameters.
- Q. The pre-payment reports are required to be produced during OIG Audits.**
- A. We will have discussions with OIG to inform them the pre-payment report will no longer be generated.
- Q. The pre-payment reports are needed for Cost Reports to verify bad debt claims for 72 Codes & Bad Debt Process.**
- A. Providers will receive remittances detailing rejected claims and zero paid claims. Medicare claims will crossover directly to the Department and the Medicaid payment amounts will be included on provider remittances.
- Q What is the turnaround time on the mailing of paper remittance advices?**
- A. Remittance advices are mailed daily, about two days after the voucher date. Remittance advices are mailed to the Payee address HFS has on record, which is not always the person or entity handling the reconciliation of payment for the facility. It is the provider's responsibility to assure proper routing within their organization. Payee address information can be updated through the IMPACT Provider Enrollment system. If you are missing paper remittance advices you may call the voucher request line at 217-782-7149.