NextLevelHealth
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June 2018

Provider Memorandum

Claim and Encounter Errors

As stated in previous provider notices, the Illinois Department of Healthcare and Family Services (HFS) requires Managed Care Organizations (MCO) to meet very specific claim submission standards requiring particular and exact data elements on claims submissions.

This Provider Memorandum is an effort to improve the acceptance rate of NextLevel Health (NLH) encounter data according to HFS and to ensure correct claim submission for services rendered to our members.

To prevent improper payment, NLH will enforce National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits within our claims processing system for all billing dates of service 6/1/18 and after. What does this mean? All claims received that have been submitted incorrectly will be rejected in accordance with HFS Chapter 200, Hospital Handbook and Hospital Appendices.

To assist providers with accurate claim submissions, NLH has identified the most common errors received and helpful resubmission tips as a reference below. Please note, not all errors can be covered in this document. The following is offered to help address the most common errors submitted to NLH.

Error	TIP…
Missing Covered Days	Review Covered Days. The number of Covered Days must be entered on all inpatient, hospice and outpatient series claims. Submit a correct claim.
Incorrect/Missing Non-covered days	Inpatient claim submitted where difference between Statement From Date and Through Date for Occurrence Span Code 74 doesn't match with Non-Covered Days Value Code submitted, or, when Value code 81/amount not submitted for the days that were not covered
Accommodation Days are not equal to covered days.	If the total accommodation days billed do not match the total covered days the claim will reject.
Service units greater than covered days.	This means the sum of Service Units in claim line level is greater than or not equal to Covered days value code 80 amount(s). Review and resubmit.
Illogical Patient status code for Billing status	Inpatient claim (or outpatient series claim) submitted where Type of Bill indicates patient still in hospital as inpatient, or residing in a nursing facility, or patient coming back for treatment, while Patient Discharge Status indicates patient was discharged.
Invalid Interim Claim	An interim claim was received from a DRG Hospital for general inpatient and must be billed for the entire period covering admit through discharge.
Invalid Type of Bill	A claim was received with an invalid Type of Bill code. Submit corrected claim. LTC Billing: LTC claims must have specific bill types associated with certain categories of service (which are derived by taxonomy codes). Correct either the Bill Type or Taxonomy Code on the claim and resubmit.
Duplicate Payment Voucher	A claim was received in which a duplicate service was previously paid. If the rejected procedure code was for a procedure or service, other than a lab test or x-ray, that was done more than once on the same date of service, rebill on a new claim using the appropriate corresponding "unlisted" procedure code.

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Error	TIP...
Missing/Invalid Taxonomy Code	A claim was submitted without a taxonomy code or an invalid taxonomy code. Review and resubmit claim with the appropriate taxonomy code. Refer to the taxonomy codes in Chapter 300, Appendices 4 and 5.
Missing/Invalid Attending NPI	A claim was received with an invalid NPI or the NPI was not reported for the Attending Physician, which is required on all claims except for outpatient renal dialysis services. Review and resubmit with the appropriate NPI for the Attending Physician.
Missing/Invalid Value Code for Covered Days Series Claim	UB-04 claims only: Series claims require the number of treatment days to be reported in covered days. Value Code 80 and amount for covered days is missing or invalid. The number of covered days is to be reported right justified to the left of the dollars/cents delimiter.
Recipient Not Enrolled in Designated Plan	Department records reflect that the participant was not enrolled in the managed care plan listed on the claim. Review patient's records to ensure that the correct Recipient Identification Number was used for the dates of service being billed. If an error occurred, rebill with the correct information. If no error occurred, member not eligible, no payment can be made.
Missing Admitting Diagnosis	The Admitting Diagnosis Code FL76 was missing on the submitted claim. Admitting Diagnosis should not be used when claim does not involve inpatient admissions. Required on claims with Bill Type 012x, 022x and inpatient claims except 028x, 065x, 066x, 086. Remove the Admitting Diagnosis and resubmit.
Provider Not Enrolled For COS/Date of Service	COS-Specialty/Subspecialty billed was not active in the provider's IMPACT record for the date of service billed or the provider has not selected the Specialty/Subspecialty. Please verify accuracy of the Specialty/Subspecialty and, if necessary, update the IMPACT record. Do not resubmit the claim until a new Provider Information Sheet is received verifying that the update to IMPACT has been made in the Legacy MMIS claims processing system.

A listing of error codes and their explanations can be found at www.illinois.gov/hfs/medicalproviders/handbooks under 'Additional Resources for Providers'.

We appreciate your continued participation in NextLevel Health's network of valued providers. Please contact your Provider Service Representative if you have any questions or you may contact the Provider Services Department at 1-833-ASK– NLHP (275-6547) or via email at provider.services@nlhpartners.com.

Sincerely,

Theodore W. Dixon III
Vice President of Provider Services