BlueCross BlueShield of Illinois

# Common Issues and Solutions for Many Medicaid Long Term Care Claim Denials

This document will help guide you when filing long-term care claims for members of our **Blue Cross Community Health Plans**[SM]. To help prevent delays in claim payments, refer to these solutions to common issues:

## P68 – PCF Does Not Match

If information in the Illinois Department of Healthcare and Family Services online portal, **MEDI**, matches your claim, but the Patient Credit File does not, remember that the Patient Credit File is not in real time as MEDI is. Please allow time for the HFS to update the Patient Credit File. Once updated, claims will be adjusted accordingly.

If you know your resident is not yet on the Patient Credit File, do not wait to file the claims. Timely filing still applies. Additional details can be found on the **Illinois Association of Medicaid Health Plans Long Term Care FAQ webpage**.

## H48 – Unit Value Billed Does Not Correspond

All dates listed on the Patient Credit File are dates allowed for payment. The discharge date is not on the Patient Credit File unless the patient expired.

If the patient status is not 30, then there must be a discharge date on the claim.

## H05 – Duplicate Claim

Make sure any corrected claim submitted has frequency code 7 and the correct claim number is populated in the X12 Clearinghouse **Claim Number LOOP of the 837I**.

If your claim is for only part of the month, review your records and confirm that there are no dates of service overlapping. Dates billed with Leave of Absence Revenue Codes should not deny as a duplicate.

## PCF Liability Updates

The Patient Credit File we receive, while not being updated in real time, also only shows a rolling history of 36 months. When HFS updates liability amounts applied more than 36 months ago, send the adjustment request with a newly printed image of the MEDI LTC Verification Page so we have the information needed to make the adjustment.

When the PCF liability does show an updated patient liability within the past 36 months, allow 30 days for our system to adjust the claim before sending an adjustment request.

## Retro Rates

HFS should send us a copy of the letter they send to providers when they retroactively change a facility's per diem. When they do not do so, we do not know a rate has been changed. We ask that providers send a copy of their retro rate letter to their Provider Network Consultant. Once we receive this letter, we ask HFS to confirm the information, as all rates are supposed to be provided to the Managed Care Organization by HFS. Once confirmed, all impacted claims will be adjusted and the pricing configured in our system in case of other claim adjustments in the future.

If you receive a retro rate from HFS, we cannot adjust your claim to pay more than the submitted billed charge. Please submit claims with your private rates in order to ensure you will always receive the total amount allowed.

## Timely Filing

Since retro rate letters are often mailed past timely filing, billing your private rate on the original claim means there is no need to attempt to file a corrected claim with a higher billed amount.

## Patient Liability Deductions

If you submit two claims on the same day for the same patient in the same month, there will be an unavoidable error in the deduction of patient liability. The claim processing system cannot see that another claim is in process at the same time. In order to avoid this, please send the second claim for your patient the next day.