Automated (Desk) Approved Scenarios		
Approval Date	**Scenario Name**	**Description**
July 18, 2014	DME during LTC	HMS will determine through data analysis of LTC claims and claims with medical equipment and\or supplies identified on the Illinois DME Fee Schedule as included in the Long Term Care per diem if separate reimbursement for per diem items occurred. Chapter M-200 Policy and Procedures for Medical Equipment and Supplies, Topic M-203, Covered Services indicates a covered service is an item or service for which payment can be made. The services covered in the program include only those reasonably necessary medical and remedial services which are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment. Topic M-204, Services Not Covered, indicates payment cannot be made by the Department to providers of medical equipment and supplies for medical equipment and supplies of Long Term Care facilities except as provided in Topic M-270. Topic M-270 Long Term Care Facility Services states Long Term Care (LTC) facilities are required to provide medical equipment, devices, and supplies commonly used in patient care as a part of the per diem reimbursement paid to the facilities by the Department. Separate reimbursement for items identified as inclusive in the LTC per diem may represent overpayments.
January 14, 2015	Incorrect Discharge Status Code	A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the time end of a billing cycle. Illinois Medicaid Handbook, Chapter H-200, Policy and Procedures for Hospital Services, Topic H-250.1, Inpatient Reimbursement Methodologies indicates hospitals reimbursed through DRG-PPS are paid a predetermined all-inclusive per discharge rate. When a patient is transferred from one acute care prospective payment system (PPS) to another acute care PPS hospital, the first hospital receives a portion of the DRG payment if the length of stay is less than the DRG Geometric Length of Stay (GLOS). An incorrect patient discharge status code may result in an improper payment to the provider.
December 3, 2014 Renewed - December 28, 2016	Not a New Patient	The Illinois Medicaid Provider Manual, Chapter A 200, Policies and Procedures for Medical Services, Section A-220.23, New Patient vs. Established Patient Classification specifies a participant may be designated as a “new patient” only once in a lifetime by an individual practitioner, partner of the practitioner or collectively in a group regardless of the number of practitioners who may eventually see the participant. When a patient is transferred within a group practice setting, a new patient Procedure Code is not to be used. The visit is classified as for an established patient. An overpayment exists when a provider is reimbursed for a new patient procedure code and the patient has received previous face to face services from the physician or the physician group practice.

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Approval Date	**Scenario Name**	**Description**
December 3, 2014	Preadmission Testing	Chapter H-200 Policy and Procedures for Hospital Services, defines inpatient services as those services provided to a patient whose condition warrants formal admission and treatment in a hospital, and that are reimbursed based on the per diem or per discharge all-inclusive rate. Topic H-250.5, Outpatient Payment Methodologies, specifies an outpatient claim must contain at least one procedure code or an emergency department or observation revenue code as listed in the APL. When any service listed in the APL is performed on a given day, all services provided on that day (excluding the exceptions above) must be billed on a single outpatient institutional claim. However, if during the same treatment span, subsequent to emergency department or observation services, the patient is admitted to the hospital as an inpatient, only the emergency room charge or the observation services may be billed on the outpatient claim. It is up to the hospital to determine which outpatient service will provide greater reimbursement. Charges incurred as a result of services provided by other outpatient departments prior to the patient's admission, such as laboratory or radiology services, are to be shown on the inpatient claim. Separate reimbursement for outpatient services other than emergency department or observation services when the patient is classified as an inpatient may represent an overpayment.
January 22, 2015	Office Visit During Inpatient	Evaluation and Management (E/M) services refers to visits and consultations furnished by physicians and qualified non-physician practitioners (NPP). Selection of an appropriate E/M CPT code depends on patient type, setting of service and level of E/M service performed. The Illinois Medicaid Provider Manual, Chapter A-200, Policies and Procedures for Medical Services, Section A-220.2, Office or Other Outpatient Visits, states "Charges may be submitted for evaluation and management services and surgical services provided by a practitioner in the office setting that are essential for the diagnosis and/or treatment of specific illness, surgical condition, or injury. "Section A-220.5, Hospital Inpatient Services, states "Billing statements submitted for hospital visits are to show the appropriate CPT Code designating the level of care provided." An overpayment exists when a provider is reimbursed for E/M services associated with an office setting while the patient is classified as an inpatient.

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Approval Date	**Scenario Name**	**Description**
December 28, 2016	Ambulance During Inpatient	When a beneficiary is classified as inpatient and is transported while in the hospital, the rendering ambulance transport provider cannot bill the charges separately from the inpatient stay. The charges would have to be included in the bill received from the hospital. The DRG payment/similar prospective payment system for inpatient services covers all items and non-physician services the patient receives during their inpatient stay. The transport may include transportation of a beneficiary that is an inpatient at the facility and transported by ambulance to and from another facility in order to receive specialized services that are not available at the hospital where the beneficiary is considered inpatient. Ambulance providers/suppliers that provide ambulance transportation services during an inpatient stay are required to bill the hospital where the beneficiary is inpatient for the ambulance services.
December 28, 2016	Professional – Modifier 57	Billing guidelines for Modifier 57 indicate an Evaluation and Management (E/M) service resulted in the initial decision to perform surgery either the day before a major surgery (90 day global) or the day of a major surgery. Global period- includes the day before surgery, the day of the surgery and the number of days following the surgery as indicated on the MPFSDB. Often, a major surgery has a 90 day post-operative period and a minor surgery has either a zero or a 10 day post-operative period. A preoperative period is the day before the surgery or the day of surgery. When an E/M service resulting in the initial decision to perform major surgery is furnished during the post-operative period of another, unrelated procedure, then the E/M service must be billed with both the 24 and 57 modifiers. Inappropriate Usage: •Appending to a surgical procedure code •Appending to an E/M procedure code performed the same day as a minor surgery. When the decision to perform a minor procedure is done immediately before the service, it is considered a routine preoperative service and not billable in addition to the procedure. •Do not report on the day of surgery for a preplanned or prescheduled surgery. •Do not report on the day of surgery if the surgical procedure indicates performance in multiple sessions or stages.
February 6, 2017	DME during Inpatient Stay	Chapter M-204, Handbook for Medical Equipment and Supplies, Policies and Procedures, Non-Covered Services: The department cannot reimburse providers of medical equipment or supplies, including but not limited to the following: Items or services provided as part of a hospital or inpatient stay.
March 14, 2017	Vaccines for Children/ Immunizations Professional	The Vaccine for Children program provides free vaccinations for children ages birth through 18 years, for members over 19 years of age these vaccines are not covered for immunizations.
March 14, 2017	Status B Indicator Codes	HCPCS/CPT Codes with a MPFSDB Status Indicator of “B” are considered bundled into payment for other services under the physician fee schedule billed on the same date by the same provider.

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June 8, 2017	Professional Claims – Inappropriate Age	Certain CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes are specific to patients of a specific age. This edit identifies claims paid with service codes that are incorrect for the patient's age.
June 8, 2017	Inpatient Readmissions	Initial Admission shall mean an admission to a hospital that is followed by a subsequent readmission or readmissions within 30 days that are determined to be clinically related. The readmission would apply to the same or another hospital. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge.
June 8, 2017	Professional Claims – Excessive Units of Per Diem Codes	Based on CPT Manual Current Procedural Terminology, initial and subsequent hospital care codes, nursing facility codes and hospital observation codes should only be billed once per date of service.
June 8, 2017	State Code Combination Rules/Regulations Professional Claims	The Illinois Department of Healthcare and Family Services requires providers billing for member eligible services to adhere to all coding and billing requirements as set forth below. Rules and regulations found in the manuals reference codes not reimbursable when billed together. These rules vary by section and can be found in greater detail within the sample set provided. An overpayment exists when both identified codes are billed and paid. The code identified as the "deny" code would be subject to recovery. Examples are: Chapter A-200/Policy and Procedures for Medical Services Section A-240/Allergy Services: A-240.2 Desensitization Injections (Immunotherapy) The department will not pay the all-inclusive CPT Codes that represent the allergenic extract preparation and provision service as well as the injection service. Separate coding for each service should be submitted. Payment for an office visit at the same time is only payable, when a significant separately identifiable evaluation and management service by the same practitioner on the same day the immunotherapy service is performed. Codes billed and paid: 95165 or 95144 with 99214 or 99211 Chapter M-200/Policy and Procedures for Medical Equipment and Supplies An apnea monitor is considered purchased and patient-owned after 12 months of rental. All related supplies and accessories, not limited to the following, are included in the rental period and cannot be billed separately: belts, Ambu bag, electrodes, leads, and cables. The rental allowance also includes training sessions for caregivers on infant CPR and on use of the monitor, retrieval and interpretation of data from the event recorder, and submission of compliance

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		downloads. Supply items for the apnea monitor may be approved separately, if the apnea monitor is already owned. Codes billed and paid: A4556 with E0619
June 8, 2017	Professional Claims Facility Claims outside of group based pricing	The Centers for Medicare and Medicaid Services (CMS) identify certain services and/or supplies where the service is "bundled" into the payment of other paid services. Separate payment for these identified services and/or supplies should not be made. In addition, the State of Illinois may further identify services and/or supplies to be bundled into other payments. This is an industry standard practice applicable across many program types. An overpayment exists when a bundled code is paid in addition to the other primary services billed ("unbundled" payment). The code identified as a bundled code would be subject to recovery.
September 28, 2017	Professional Claims – Incidental Procedures	Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package. Surgical procedures considered incidental to, or a component of, the major procedure will not be paid separately from the major code. According to the Illinois Department of Healthcare and Family Services Practitioner Fee Schedule Key codes with a Surgery Indicator of "I" are considered incidental. These procedures may not pay separately when billed with visit or other surgical codes.
September 28, 2017	Professional Claims – Chiropractic Services not covered	According to the Illinois Administrative Code, effective July 1, 2012, payment shall only be made for chiropractic services provided to recipients under the age of 21. This scenario will target recipients who received benefits for chiropractic services after their 21st birthday.
November 1, 2017	E&M Codes w/out Modifier 25 billed with Allergy Injections and Testing	Query identifies paid claims for E&M services w/out modifier 25 on the same DOS as allergy injections or testing services. Modifier 25 identifies a significant, separately identifiable E&M service for the same patient by the same physician on the same day of a procedure or other service (Note: "Same physician" includes physicians in the same group practice who are in the same specialty.) Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure(s) is performed, information substantiating the E/M service must be clearly documented with the use of modifier -25. Modifier - 25 may be appended only to E/M service codes and then only for those within the range of 99201-99499. CPT codes 99201-99215 and 99241-99245 are not payable on the same DOS as allergy injections or testing services, unless modifier 25 is billed. The Query Result provided are providers that billed without Mod 25. According to IL Policy a preventive medicine CPT code and an office or other outpatient evaluation and management CPT code during the same session are not separately reimbursable unless mod 25 is used. There is no repricing for this query. It a full recovery. Provider can

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		correct claim by resubmitting claim with the accurate modifiers if within timely filing.
November 1, 2017	Global Days 0/10/90	The Department of Health and Human Services Centers for Medicare & Medicaid Services global surgical package, also called global surgery (or global surgery days), includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Payment for the surgical procedure includes the pre-operative, intra- operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. For purposes of this edit, we will be targeting Evaluation & Management (E&M) CPT (Current Procedural Terminology) codes only.
November 28, 2017	Professional Claims - H codes during inpatient	The edit focus is on Mental Health (psychiatric) billed while inpatient. The query identifies paid claims billed with H Codes without POS 21 (Psychiatric Inpatient) during an inpatient date of service span. Findings are based on POS 11 (Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis) while the patient is inpatient. Note: Inpatient services include all covered services provided to patients during the course of their inpatient stay, whether furnished directly by the hospital or under arrangement, except for direct-care services provided by physicians, podiatrists, and dentists. H Codes are generally codes that are for housing or medication services. Since the member is IPH, services should not be covered in the absence of POS 21.
November 28, 2017	E&M Codes w/out Modifier 25 billed with Hydration, Drug and Chemotherapy Administration.	Query identifies paid claims for E&M services w/out modifier 25 on the same DOS as drug and chemotherapy administration. Modifier 25 identifies a significant, separately identifiable E&M service for the same patient by the same physician on the same day of a procedure or other service (Note: "Same physician" includes physicians in the same group practice who are in the same specialty.) Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure(s) is performed, information substantiating the E/M service must be clearly documented with the use of modifier -25

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		Modifier -25 may be appended only to E/M service codes and then only for those within the range of 99201-99499. There is no repricing for this query. It would be a full recovery, and the provider can correct the claim by resubmitting it with the accurate modifiers if within timely filing.
December 22, 2017	DME Incontinence Supplies excessive units	Providers who dispense equipment or supplies on a monthly basis, for example, incontinence supplies, must confirm orders each month prior to dispensing. The confirmation should document the number of items needed as well as the name of the specific items needed for the subsequent month. This scenario identifies DME-Incontinence Supplies billed more than allowed, within a span of 30-days, or paid more than the maximum quantity allowed on the same date. per the IL fee schedule
April 13, 2018	DME More Than Purchased Price	Providers that dispense equipment or supplies are reimbursed based on the IL specific fee schedule, rules and regulations. Within the fee schedule there are limits to reimbursement amounts and number of units that should be dispensed within specific time-periods. This edit will look at the DME amounts paid for Purchased equipment and pull all claims that have paid amounts that are over the actual purchase amount. The query will locate HCPCS codes to determine if the DME claim paid more than the purchase price by using the IL DME Fee Schedule. This will determine if the claim paid more than the fee schedule amount. The claims that have paid more than the fee schedule amount would be identified as overpayments

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January 14, 2015-November 30, 2017 (Transition to Inpatient Acute Care Hospital Services Query)	Inpatient Hospital Reviews – Appropriateness of Setting	Inpatient hospital claims will be reviewed to determine if an inpatient setting was appropriate based on Illinois Medicaid policy. HMS will refer to McKesson Interqual Guidelines for accepted clinical criteria regarding admission status and level of care determinations. The Handbook for Hospital Services, Chapter H – 200 , Policy and Procedures, Section H – 262 states " General inpatient hospital services are defined by the department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the department has established specific participation requirements. Inpatient services are covered when a patient's medical necessity for services on an inpatient basis are documented. Reimbursement will not be made for services that were billed as acute inpatient care and subsequently denied in the review process as not being medically necessary."
May 4, 2015-November 30, 2017 (Transition to Inpatient Acute Care Hospital Services Query)	Newborn DRG Upcoding	Data analysis is performed on inpatient hospital claims paid under the Diagnosis Related Group (DRG) system to validate the accuracy of the provider's ICD-9-CM coding of diagnosis, procedures and other coding that impact the DRG assignment. HMS has identified newborn claims where the DRG assignment for the newborn claim appears inconsistent with the claim attributes. Assignment of a patient to a particular DRG is based on information in the medical record. Each DRG is assigned by taking information from inpatient claim forms including ICD-9-CM diagnosis codes, surgical procedures performed during the hospitalization and patient demographics to determine the proper DRG for the hospital admission. Missing data may result in assignment to a DRG that does not fully reimburse the hospital for the costs of providing services. Other data errors could result in the admission being incorrectly assigned to a higher-paying DRG. Clinical and coding review is conducted to validate the principal diagnosis, secondary diagnoses, procedures, and discharge status affecting or potentially affecting the DRG assignment.
March 10, 2016 – November 30, 2017 (Transition to Inpatient Acute Care Hospital Services Query	Inpatient DRG Validation	HMS will utilize data mining techniques where the demographics, billing attributes, diagnosis codes, procedure codes, and/or factors impacting the DRG assignment appears to be inconsistent with other attributes of the claims. HMS will conduct complex medical record review of the claims by: reviewing medical record documentation to validate the DRG assignment, validating the accuracy of the hospital's coding of all diagnoses and procedures that impact the DRG, conduct the review based on accepted principles of coding practice consistent with established coding guidelines utilizing the

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		version in place at the time the services were rendered, and by utilizing experienced certified coders. DRG's are assigned using the principal diagnosis, additional diagnoses, the principal procedure and additional procedures, age, sex, and discharge status. The purpose of DRG validation is to ensure the diagnostic and procedural information and the discharge status of the recipient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the recipient's medical record. Beginning July 1, 2014, HFS processes inpatient hospital claims utilizing the All Patient Refined Diagnosis Related Group (APR-DRG) payment system. Inpatient claims prior to this date were processed utilizing the HFS DRG payment system.
June 16, 2017	Inpatient Acute Care Hospital Services	HMS Conducts a comprehensive reviews of acute care inpatient hospital claims to ensure compliance with all applicable State and Federal regulations. This includes review for inappropriate setting issues, coding errors and other billing errors that may affect payment. **Place of Service Review:** Inpatient hospital claims will be reviewed to determine if an inpatient setting was appropriate based on Illinois Medicaid policy. HMS will refer to McKesson Interqual Guidelines for accepted clinical criteria regarding admission status and level of care determinations. The Handbook for Hospital Services, Chapter H – 200, Policy and Procedures, Section H – 262 states "General inpatient hospital services are defined by the department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the department has established specific participation requirements. Inpatient services are covered when a patient's medical necessity for services on an inpatient basis are documented. Reimbursement will not be made for services that were billed as acute inpatient care and subsequently denied in the review process as not being medically necessary." **Diagnosis Related Group (DRG) Validation Review:** Inpatient hospital providers may receive payment based on a diagnosis-related grouping (DRG) reimbursement methodology. Proper coding of all diagnosis and procedure codes, as well as accurate and complete recording of all data elements that affect the DRG assignment, is critical to ensuring that the hospital is properly reimbursed. HMS will utilize data mining techniques where the demographics, billing attributes, diagnosis codes, procedure codes, and/or factors impacting the DRG assignment appears to be inconsistent with other attributes of the claims. HMS will conduct complex medical record review of the claims by: reviewing medical record documentation to validate the DRG assignment, validating the accuracy of the hospital's coding of all diagnoses and

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		procedures that impact the DRG, conduct the review based on accepted principles of coding practice consistent with established coding guidelines utilizing the version in place at the time the services were rendered, and by utilizing experienced certified coders. DRG's are assigned using the principal diagnosis, additional diagnoses, the principal procedure and additional procedures, age, sex, and discharge status. The purpose of DRG validation is to ensure the diagnostic and procedural information and the discharge status of the recipient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the recipient's medical record. Beginning July 1, 2014, HFS processes inpatient hospital claims utilizing the All Patient Refined Diagnosis Related Group (APR-DRG) payment system. Inpatient claims prior to this date were processed utilizing the HFS DRG payment system.
March 10, 2016	Hospice Services	Title 77 of the Illinois Administrative Code, Part 280, Section 280.1000 defines hospice care as a program of palliative care that provides for the physical, emotional, and spiritual care and needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms. The Illinois Provider Manual, Chapter K-200, Hospice Services, Section K-211.3, Requirements for Election, indicates hospice care is available only if the following conditions are met. The patient's physician and/or hospice medical director certify that the patient is terminally ill (for hospice purposes terminal illness is defined as a life expectancy of six (6) months or less if the terminal illness runs its normal course); and The patient or legal representative, in the event the patient is physically or mentally unable to sign, signs an election statement indicating an informed choice of hospice benefits for the terminal illness; and The patient receives care from a Medicare certified hospice that is enrolled with the Department to provide hospice services; and The services are provided in accordance with a plan of care established by the patient's attending physician, the medical director or physician designee and the interdisciplinary group. The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed. HMS will review hospice provider claims and request supporting documentation from hospice providers to ensure provider

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		compliance with Illinois Medicaid eligibility, service coverage and documentation requirements for hospice services. Reviews will focus on the following: 1. We will review to determine if initial and subsequent enrollment/certification procedures were appropriately followed. 2. Sufficient documentation must be present to confirm the life expectancy of the recipient was six months or less if the terminal illness or disease follows its usual course. 3. Sufficient documentation, using objective as well as subjective data must be included in the medical record to substantiate the patient is in the terminal stage of their illness based on the relevant disease specific Local Coverage Determination (LCD) guideline as required to qualify for hospice level of care. To the extent that providers did not comply with Illinois Medicaid requirements, or if compliance with requirements cannot be documented, HMS will recommend recoupment of Medicaid payments for the affected periods of service.
May 23, 2018	Professional claims - Trastuzumab (Herceptin) J9355, Multi-Dose Vial Wastage	Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must accurately represent the dosage increment specified in the HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient. If the drug dose used in the care of patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Multi-use vials are not subjective to payment for medication wastage. Herceptin (J9355: INJECTION, TRASTUZUMAB, 10MG) is supplied from the manufacturer in a 440mg multi-dose vial and a 150mg single-use vial. When using the multi-use vials, providers should only be billing units of J9355 associated with the amount of drug administered to the patient. Drug waste is not paid and should not be billed for drugs supplied in multi-use vials.

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Approval Date	**Scenario Name**	**Description**
May 23, 2018	Inpatient or Outpatient Hospital Services-Automatic Implantable Cardiac Defibrillator	The automatic implantable cardiac defibrillator (AICD) is an electronic device designed to detect and treat chaotic, extremely fast, life-threatening heart rhythms, called fibrillations, by delivering a shock to the heart, restoring the heart's normal rhythm. A National Coverage Determination (NCD) governs Medicare coverage for the device, which costs approximately $25,000. The Centers for Medicare and Medicaid Services implemented the NCD based on clinical trials and the guidance and testimony of cardiologists and other health care providers, professional cardiology societies, cardiac device manufacturers and patient advocates. The NCD provides that AICDs generally should not be implanted in patients who have recently suffered a heart attack or recently had heart bypass surgery or angioplasty. The medical purpose of a waiting period - 40 days for a heart attack and 90 days for bypass/angioplasty - is to give the heart an opportunity to improve function on its own to the point that an ICD may not be necessary. The NCD expressly prohibits implantation of ICDs during the specific waiting periods.

Complex Financial Audit Approved Scenarios		
Approval Date	**Scenario Name**	**Description**
March 21, 2016	Credit Balance Audit	The review will consist primarily of an analysis of transactions affecting the financial accounts of Illinois Medicaid recipients. HMS will inform HFS of overpayments and third party payments made to the hospital provider which were not credited to DHS. Reviews may occur onsite or offsite, depending on the information received from the provider. HMS will initiate the audit with a letter detailing the process and documentation required for participation. The review will take approximately one to two days to complete depending on the availability of hospital personnel and records. In order to complete the review HMS will ask that patient accounting personnel are available during the review if the review is being conducted onsite. Upon completion of the audit, HMS will issue a report of findings. Each finding is reviewed with the facility and sign off is given before HMS submits the findings to HFS for recovery. Providers disagreeing with HMS' findings will have an opportunity to discuss and dispute the findings.
March 21, 2016	Long Term Care Audits	HMS will perform a complete improper payment review of all Medicaid long-term care facilities. The review will be conducted at the HMS office and will include a comprehensive analysis of pertinent data utilizing the state's eligibility and paid claims information, and financial records obtained from the providers. Both patient liability and claim improper payments will be identified. HMS will review the Medicaid eligibility and claims processing manuals pertaining to LTC facilities in order to gain a full understanding of the policies

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March 21, 2016	Long Term Care Audits	governing these types of facilities in the state. The HMS LTC Improper Payment Review Program will be tailored to meet the needs of the Medicaid program based on the research conducted. HMS will perform improper payment reviews that will entail a three year look-back from the inception of the program and will involve review of the earliest two and a half years to allow for finalization of financial activity in the most recent six months.
April 16, 2018	Credit Balance - Dialysis/ESRD Self- Disclosure	Credit balance is an accounting term used to describe the situation when the payments and/or adjustments for a claim exceed the charges. When this occurs, the claim is in a less than zero (negative) or "credit" status. A credit balance audit is a financial account review of all suspect Medicaid accounts for a provider in order to identify overpayments and/or underpayments. The causes of Credit Balances can be monetary in nature (COB, retroactive payments, duplicate payments, incorrect payments) or non-monetary (inaccurate postings, charges written off in excess of amounts actually billed, provider NR collection systems modeling net revenue at the time of billing, charge master issues, etc.). Claims in a credit status are typically reviewed and resolved on a claim-by-claim basis. Resolving a credit balance often entails reviewing all the various claim documentation including Explanation of Benefits (EOBs); Remittance Advice notifications (RA's); claim charges and adjustments; and patient accounting information as well as financial documentation (Aged Trial Balance/ATS, Credit

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Approval Date	**Scenario Name**	**Description**
		Balance Report, and Debit adjustment reports). Self-disclosure reviews are conducted for provider types typically not reviewed by traditional credit balance (i.e. non acute care facilities). This affords the providers with a mechanism to "self-disclose" overpayments that are due back to the IL Medicaid program. This scenario is focused on: Dialysis/ESRD providers.
April 16, 2018	Credit Balance -Amnesty/Self Disclosure	Credit balance is an accounting term used to describe the situation when the payments and/or adjustments for a claim exceed the charges. When this occurs, the claim is in a less than zero (negative) or "credit" status. A credit balance audit is a financial account review of all suspect Medicaid accounts for a provider in order to identify overpayments and/or underpayments. The causes of Credit Balances can be monetary in nature (COB, retroactive payments, duplicate payments, incorrect payments) or non-monetary (inaccurate postings, charges written off in excess of amounts actually billed, provider AIR collection systems modeling net revenue at the time of billing, charge master issues, etc.). Claims in a credit status are typically reviewed and resolved on a claim-by-claim basis. Resolving a credit balance often entails reviewing all the various claim documentation including Explanation of Benefits (EOBs); Remittance Advice notifications (RA's); claim charges and adjustments; and patient accounting information as well as financial documentation (Aged Trial Balance/ATS, Credit

Complex Financial Audit Approved Scenarios		
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		Balance Report, and Debit adjustment reports). Amnesty reviews are conducted for provider types typically not reviewed by traditional credit balance (i.e. non acute care facilities). This affords the providers with a mechanism to "self-disclose" overpayments that are due back to the IL Medicaid program. This scenario is open to all provider types.