**Section 140.74 Resolution of Claims Related to Inaccurate or Updated Enrollment Information**

a) Payment shall be made for a medically necessary covered service when payment is initially denied due to inaccurate or updated enrollment information on the date of service when the provider:

1) Submits documentation to the entity responsible for payment pursuant to subsection (c) that the provider verified the client's enrollment on the date of service by using the Recipient Eligibility Verification Program (REV), the Medical Electronic Data Interchange (MEDI), or any other electronic system that the Department designates for electronic enrollment verification; and

2) Meets all other requirements for providing the medically necessary covered service on the date of service.

b) In order to receive payment for the medically necessary covered service rendered, the provider must also meet the following:

1) For services that required prior authorization, the provider must submit documentation to the entity responsible for payment pursuant to subsection (c) that the prior authorization request was approved by the previous entity to which the client was identified as being enrolled pursuant to subsection (a). For services that did not require prior authorization, the provider must provide proof that no prior authorization was required by the previous entity.

A) The MCO responsible for payment pursuant to subsection (c) must accept the approved prior authorization made by the previous entity and may not impose any further prior authorization or similar requirements.

B) For services that did not require prior authorization from the previous entity, the MCO responsible for payment pursuant to subsection (c) may not impose any further prior authorization or similar requirements.

2) The provider must supply evidence of claim denial or rejection and supporting documentation of enrollment to the entity responsible for payment pursuant to subsection (c).

3) The approved prior authorization request from the previous entity, or proof that no prior authorization was required by the previous entity, and initial or resubmitted claim must be received by the entity responsible for payment pursuant to subsection (c) within the appropriate timely filing period. The timely filing period shall begin on the date on the payment voucher/remittance advice that informs the provider that the claim is denied or rejected and extend for a period of 180 days.

c) The MCO in which the client is enrolled on the date of service is responsible for payment.

d) Payment by the responsible MCO will be made as follows:

1) In-network managed care providers shall receive the payor's contracted rate that was in effect on the date of service.

2) Out-of-network and fee-for-service providers shall receive, at a minimum, the fee-for-service rate, plus any add-ons, that was in effect on the date of service.

3) A payment penalty reduction is not permissible.

e) For the purposes of this Section, documentation may include, but is not limited to:

1) REV eligibility batch file or screen print, MEDI eligibility batch file or screen print, or other eligibility statement from the electronic enrollment verification system designated by the Department and used to verify the client's eligibility on the date of service. For long term care providers, if the batch report or screen image is dated on or after the first day that the Department opens access to the enrollment verification system for purposes of verifying the client's eligibility for the covered service, it shall be accepted as the date of service verification.

2) Previous entity's policy as contained in a provider manual, provider notice, provider contract, policy memorandum, or other entity-created document that indicates that no prior authorization was required for the services rendered, or the previous entity's prior authorization approval;

3) Initial claim or resubmitted claim; and

4) Payment voucher/remittance advice or explanation of benefits (EOB) that informs the provider that the previous entity denied or rejected the claim.

(Source: Added at 41 Ill. Reg. 10950, effective August 9, 2017)