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TAF Technical Guidance: How to Use Illinois Claims Data

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Revision History

Revision Date	Authors/Changes
2/3/2020	**Sujata Chowdhury, Stephen Kuncaitis**
	Added text to clarify that the MSIS ID is used in the initial grouping of the claims into claim families. Added text to clarify that the Daisy Chain ICN approach looks at the original and adjustment ICNs for a match, but it only looks at the prior claim in the claim family (not all claims). Added text to clarify what happens when the adjudication date is missing. Added text to clarify what happens if there is ambiguity in the order of the final two claims in the claim family

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TABLES

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I. Introduction

A. Purpose

The purpose of this document is to provide instructions on how to interpret and use the Illinois TAF claims data.

B. Background and Current Issue with Illinois' Claims Data

States submit medical and pharmacy claims to Transformed Medicaid Statistical Information System (T-MSIS) on a rolling basis as they are adjudicated by state systems. As a result, the T-MSIS claims files may contain multiple versions of a claim, reflecting the original claims as well as any voids, adjustments, or resubmissions. In order to improve the usability of the data for analysis, the T-MSIS Analytic File (TAF) includes only a single service use record that represents the final disposition of the claim.

As described in the T-MSIS Data Dictionary Appendix P.01, "Submitting Adjustment Claims to T-MSIS," the final action algorithm was implemented in the federal system to select a single claim record for inclusion in the TAF. The algorithm links together the original claim and all related adjustment claims into a "claim family" that is assigned a common claim family ID. The algorithm then determines the "final action claim" within the family. The expectation is that every claim family will have one final action claim that represents the final version of the claim after all adjustments have been made. However, Illinois's claims data are submitted in a non-standard format that does not allow the final action algorithm to perform as designed.

Discussions with the Illinois state team indicate that the state is using a Medicaid Management Information System (MMIS) that has not been updated for many years. The state team acknowledged that it may not be following the industry standard, given the challenge of making changes in the current claims adjudication process.

Instead of adjusting original claims through void and replacement records, Illinois submits T-MSIS records that represent marginal adjustments to the original claim. In a family of one original and one or more marginal adjustment claims, no one claim record contains all of the final action data for the claim family. Unlike a normal T-MSIS claim family in which the final action payment amount and all other final action attributes are in the last version of a claim in the family, the final action payment amount in a marginal adjustment claim family must be netted across all claims in the family, and attributes missing from the last version of the claim must be retrieved from older versions. Using only the last version of the claim in a claim family in Illinois will provide an incorrect payment amount, and other important data such as procedure codes will be lost.

In light of these issues, the T-MSIS Operations Team evaluated Illinois' data and in June 2019 incorporated into the claim family algorithm the logic that can handle marginal adjustments. With this change, all claims in a family that did not end with a void or denied claim are included in the TAF claims files for Illinois. This will allow users of the TAF data to construct the equivalent of a final action claim that suits their analytical needs. This short-term solution will help to make the data usable until the state can make the changes required to address this issue. As a result of the changes made to the algorithm, users will see multiple final action claims within a claim family in Illinois' TAF data.

This guide is intended to assist these users by providing instructions for how to interpret and use the Illinois TAF data. The remainder of this section provides TAF users with instructions for how to use Illinois' TAF data to tabulate beneficiaries, service use, and expenditures. Section 2 provides additional detail on how the final action algorithm operates in most states and the modifications made to its operation for Illinois. Section 3 provides detailed information about how Illinois captures different types of adjustments in its T-MSIS data.

C. How to Use Illinois' Claims Data for Analysis

TAF users will need to adjust their approach to use Illinois' data for most analyses.[1] Table 1 presents instructions for how to create key utilization and cost measures for this state in a way that would be most comparable to other states.

Table 1. How to calculate key measures using Illinois' claims data

Measure type	How to calculate	Key data elements and logic
Utilization	Count no more than one service per distinct claim family	If the claim type (CLM_TYPE_CD) is not '4', 'D', 'X', or 'Y' then count distinct original internal control numbers (ORGNL_CLM_NUM) from claim header, and count only one record per ORGNL_CLM_NUM. If CLM_TYPE_CD is '4', 'D', 'X', or 'Y', then count distinct adjustment internal control numbers (ADJSTMT_CLM_NUM) from the claim header, and count only one record per ADJSTMT_CLM_NUM. Though claims with CLM_TYPE_CD '4', 'D', 'X', or 'Y' typically do not represent service utilization.
Expenditures	Sum payments across all records in a claim family	Sum the Medicaid paid amount across all relevant claim records (e.g., record with the same MSIS_IDENT_NUM, same ORGNL_CLM_NUM, and same provider ID). The payment amount may appear in the total Medicaid paid amount (TOT_MDCD_PD_AMT), the service tracking payment amount (SRVC_TRKNG_PYMT_AMT) or both. Users should be careful not to double-count payment amounts reported in both fields on the same claim.
Number of beneficiaries	Count distinct unique beneficiary identifiers (MSIS ID)	Count the distinct MSIS_IDENT_NUM values from the header record of relevant claims

1. Measuring service utilization or claim frequency

When creating measures of utilization or claim frequency, TAF users should be careful to count only one record per claim family. Claim families can be identified using either original claim number (ORGNL_CLM_NUM) or the adjustment claim number (ADJSTMT_CLM_NUM), depending on the type of claim (CLM_TYPE_CD). Users can examine the type of claim to determine whether to use the original claim number or the adjustment claim number to define the claim family.

[1] Variable names refer to the TAF variables unless otherwise noted.

In some circumstances, TAF users may need to select a single record from among the claim family to represent the entire family in the analysis. One approach that users could take is to select only the original claim from the family, identified as those with an adjustment indicator value of "0." (Illinois uses an adjustment indicator value of "0" to identify both original claims and negative supplemental adjustment claims, so in some cases this will identify more than one record per claim family, and in those cases TAF users may elect to either drop all records from the claim family, or further de-duplicate to a single record using the original claim number, adjustment claim number, and/or adjudication date.) The payment amounts captured on the original claim will not be complete, and some other fields may also change in subsequent adjustment records. However, the original record is likely to contain the most complete non-payment information (such as diagnosis code, procedure code, revenue center code, and so forth), and as a result is likely to be the most usable record in the claim family for analytic purposes.

2. Measuring expenditures

When measuring expenditures, TAF users should include all records in a claim family. On marginal adjustment records, the amount paid by Medicaid is often, but not always, reported in the service tracking payment amount (SRVC_TRKNG_PYMT_AMT) rather than in the total Medicaid paid amount (TOT_MDCD_PD_AMT). As a result, TAF users should look in both fields to identify payment amounts. In some cases, the state reported the same payment information in both the service tracking payment amount and the total Medicaid paid amount. Users should be careful not to double-count payments reported in both fields on the same claim.

3. Measuring beneficiaries

When identifying or counting beneficiaries associated with certain types of claims, TAF users should be careful to count only one record per claim family. This is particularly important if identifying beneficiaries using logic that requires multiple distinct claims or episodes of care for the same condition or service in order to be included in the study population, or if counting the number of services received by a single beneficiary.

One potential approach is to identify all claim records in Illinois that meet the analytic criteria (for example, all claims with the diagnosis code of interest), then to count the number of unique MSIS IDs (MSIS_IDENT_NUM) among those claims.

Table 2 provides example data records for the purpose of showing how to calculate different measures. In the table, beneficiary M01 has four claims. Record 1 represents an original claim and records 2, 3, and 4 are adjustments. These records represent the following sequence of events:

- Record 1 - Provider 1111000001 submits a claim for beneficiary M01 for $950, and Illinois adjudicates it and agrees with the amount of $450.
- Record 2 - The state agrees to pay an additional amount of $350 and initiates a debit adjustment claim.
- Record 3 - The state agrees to pay additional payment amount of $100 and initiates a debit adjustment claim.
- Record 4 - The state decides to recoup the payment amount of $125 and initiates a credit adjustment claim.

Beneficiary M02 has two claims. Record 5 is an original claim, and record 6 is an adjustment. These records represent the following sequence of events:

- Record 5 - Provider 1111000001 submits a claim for beneficiary M02 for $375, and the state adjudicates it and agrees with the amount of $200.
- Record 6 - The state agrees to pay an additional amount of $100 and initiates a debit adjustment claim.

If TAF users were interested in measuring the number of services represented in the records captured in Table 2, they would count the number of unique original claim numbers (because in the example the adjustment indicator is not equal to 5 or 6) to determine these records represent two claims.

If TAF users were interested in measuring total spending, they would sum across the total Medicaid paid amount to arrive at $775 for beneficiary M01 and $300 for beneficiary M02.

If TAF users were interested in measuring the number of beneficiaries receiving services, they would count the number of unique MSIS IDs to arrive at two beneficiaries.

Table 2. Example of Medicaid fee-for-service claim records from Illinois

Record #	BLG_PRVDR_NUM	MSIS_IDENT_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	DGNS_1_CD	SRVC_BGNNG_DT	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	TOT_MDCD_PD_AMT
1	1111000001	M01	2018100022	NULL	D123	20181015	0	20190401	950.00	450.00
2	1111000001	M01	2018100022	2018100033		20181015	4	20190415	0.00	350.00
3	1111000001	M01	2018100022	2018100044		20181015	4	20190510	0.00	100.00
4	1111000001	M01	2018100022	2018100055		20181015	0	20190615	0.00	-125.00
5	1111000001	M02	2018100066	NULL	D123	20181015	0	20190615	375.00	200.00
6	1111000001	M02	2018100066	2018100077		20181015	4	20190625	0.00	100.00
Metric #1: Number of distinct claims by ORGNL_CLM_NUM									**2**	
Metric #2: Total expenditures (TOT_MDCD_PD_AMT)									**$1075.00**	
Metric #3: Number of unique beneficiaries by MSIS_IDENT_NUM									**2**	

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II. Description of the Final Action Algorithm

At a high level, the final action algorithm links together the original claim and all related adjustment claims into a "claim family" that is assigned a common claim family ID. Next, the algorithm determines the "final action claim" within the family. However, since Illinois' T-MSIS claims are submitted in a non-standard format, the final action algorithm works differently in this state. How this process works in most states, and the modifications made for Illinois, are described in this section.

A. Identifying Claim Families

A "claim family" is a set of paid, denied, or void claims that have been adjudicated and have a related internal control number (ICN). This grouping of the original claim and all of its subsequent void and adjustment claims shows the progression of changes that have occurred since the claim was first submitted. Claims are first organized by source file type and then by MSIS ID. Then the ICNs on claims from the same source file type with the same MSIS ID are compared to create claim families.

There are two ways to link original claims and their subsequent adjustments into a claim family:

- All the claims in the family have the same original ICN while the adjustments each have a different adjustment ICN. This is known as the "Original ICN approach." This is the approach used by Illinois, among other states.
- Each subsequent adjustment links back to only the prior claim in the family. The original and the first adjustment have either a common original ICN or adjustment ICN. Then if there was a second adjustment it would have an original ICN or adjustment ICN in common with the first adjustment but not with the original claim. Then if there was a third adjustment it would have an original ICN or adjustment ICN in common with the second adjustment but not the first adjustment or original. This is known as the "Daisy Chain ICN approach." Some other states use this approach.

1. Example of the original ICN approach

Under this approach, a state assigns an ICN to the initial adjudicated version of the claim or encounter and records this identifier in the original claim number. If adjustment claims are subsequently created, the ICN assigned to the initial adjudicated version of the claim or the encounter is carried forward on every subsequent adjustment claim. Table 3 illustrates how the original claim number and the adjustment claim number on the members of a claim family are populated when the original ICN approach is used. Adjudication date is then used to sort claims within a family to determine the sequence in which each adjustment occurred, and which claim is the final action. Medicaid paid date or check effective date are used if adjudication date is missing or the same across claims.

Table 3. Relationship of the original claim number and the adjustment claim number under the original ICN approach

Event	ADJDCTN_DT	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND
On 5/1/2014, the state completes the adjudication process on the initial version of the claim	5/1/2014	1	NULL	0
On 7/15/2014, the state completes a claim re-adjudication/adjustment	7/15/2014	1	2	4
On 8/12/2014, the state completes a second claim re-adjudication/adjustment	8/12/2014	1	3	4
On 9/5/2014, the state completes a third claim re-adjudication/adjustment	9/5/2014	1	4	4

2. Example of the daisy chain ICN approach

Under this approach, a state records the ICN of the previous final adjudicated version of the claim or encounter in the original claim number of the adjustment claim record. If additional adjustment claims are subsequently created, the original claim number on the new adjustment claim points back only to the previous claim. Table 4 illustrates how the original claim number and the adjustment claim number on the members of a claim family are populated when the Daisy Chain ICN approach is used.

Table 4. Relationship of the original claim number and the adjustment claim number under the daisy chain approach

Event	ADJDCTN_DT	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND
On 6/1/2014, the state completes the adjudication process on the initial version of the claim	6/1/2014	11	NULL	0
On 8/15/2014, the state completes a claim re-adjudication/adjustment	8/15/2014	11	12	4
On 9/12/2014, the state completes a second claim re-adjudication/adjustment	9/12/2014	12	13	4
On 10/5/2014, the state completes a third claim re-adjudication/adjustment	10/5/2014	13	14	4

B. Flagging Final Action Claims

In broad terms, the final action algorithm operates as follows:

- Link all the related claims, including the original and adjustments, into a claim family and assign a claim family ID. Identifying the set of related claims that represent a claim family will use different logic depending on whether the state uses the Original ICN approach or the Daisy Chain approach.
- Sequence the claims within a claim family either based on adjudication date (or Medicaid paid date or check effective date if adjudication date is missing or the same across claims) if the family uses the Original ICN approach or the order implied by the relationship between the original claim number and the adjustment claim number across claims in the family if the family uses the Daisy Chain approach.

- In all states other than those using marginal adjustments (only Illinois as of November 2019), flag the final action claim as the latest-sequenced claim in a claim family. This includes all claims regardless of status, including paid, denied, and voided claims.
- If there is ambiguity in the order of the final two claims in the claim family then the algorithm uses the information available to make a best guess at the most appropriate final action claim. If the information available is not sufficient then the claim family will not be sequenced or assigned a final action status.
- In states using marginal adjustments (only Illinois as of November 2019), flag all claims in a claim family as final action claims if the last claim in the claim family is something other than a void or denied claim.

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III. How Illinois Submits Adjustments to Claims in Different Scenarios

A. Standard Use Versus Illinois' Use of Adjustment Indicators

The adjustment indicator (ADJSTMT_IND) identifies the type of adjustment record. This data element should be used to identify an original claim, an adjustment claim, a void claim, or a gross adjustment claim. Table 5 shows the standard values for the adjustment indicator as listed in the T-MSIS Data Dictionary, version 2.2.

Table 5. Adjustment indicator values

Value	Description	Comments
0	Original claim/encounter/payment	Indicates that this is the first (and, when applicable, only) fully adjudicated transaction in a claim family (one or more claims with the related original ICN and/or adjustment ICN and typically the same MSIS ID and provider ID(s) also).
1	Void/reversal/cancel of a prior submission	Use this code to convey that the purpose of the transaction is to void/reverse/cancel a previously paid/approved claim/encounter/payment where the claim/encounter/payment is not being replaced by a new paid/approved version of the claim/encounter/payment. Typically, this would be the last claim/encounter/payment that would ever be associated with a given claim family. These records must have the same original ICN or adjustment ICN as the claim/encounter being voided. CMS expects a void transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being voided/reversed/canceled.
4	Replacement/resubmission of a previously paid/approved claim/encounter/payment	Use when the purpose of the transaction is to replace a previously paid/approved claim/encounter/payment with a new paid/approved version of the claim/encounter/payment. These records must have the same original ICN or adjustment ICN as the claim/encounter being replaced. CMS expects a replacement transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being replaced/resubmitted.
5	Credit gross adjustment	Use this code to indicate an aggregate provider-level recoupment of payments (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as negative numbers. If a credit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a credit gross adjustment are not related to any other gross adjustments (credit or debit) then the credit gross adjustment will always be treated as a distinct financial transaction.
6	Debit gross adjustment	Use this code to indicate an aggregate provider-level payment to a provider (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as positive numbers. If a debit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a debit gross adjustment are not related to any other gross adjustments (credit or debit) then the debit gross adjustment will always be treated as a distinct financial transaction.

Table 6 shows how Illinois is using in the adjustment indicator field. The adjustment indicator value for void claims is used by Illinois in the same way as other states. All other adjustment indicator values are defined and used differently than other states.

Table 6. Adjustment indicator values used by Illinois

Value	Description	Comments
0	Original claim/encounter	The state is using '0' for original claim and negative supplemental adjustment claim.
1	Void of a prior submission	The state is using '1' for void claim.
3	Credit adjustment (negative supplemental)	This value is no longer valid. The state submitted credit adjustments claims with an adjustment indicator value of '3' in earlier reporting periods. The state has started to submit the negative supplemental claim with an adjustment indicator value '0' instead of '3'.
4	Debit adjustment (positive supplemental)	The state is using adjustment indicator value '4' for additional payment; i.e., a debit adjustment positive supplement
5	Credit gross adjustment	The state is using adjustment indicator value '5' for credit gross adjustment claims. These credit gross adjustments sometimes have an original claim number that is the same as the original claim number on other claims, but the original claim number should always be ignored on Illinois' credit gross adjustments. These credit gross adjustment claims should never actually be directly associated with any other claims. Each credit gross adjustment is distinctly identified by a unique adjustment claim number.
6	Debit gross adjustment	The state is using adjustment indicator value '6' for debit gross adjustment claims. This adjustment indicator occurs only in single-family claims in Illinois. Like credit gross adjustments, the original claim number should be ignored on all debit gross adjustments. Each debit gross adjustment is distinctly identified by a unique adjustment claim number.

Note: The definitions of the adjustment indicator values were valid in earlier versions of the T-MSIS Data Dictionary, and some values and definitions are no longer valid.

B. Provider-Initiated Adjustment

Provider-initiated claim adjustments in Illinois are submitted as follows:

- A provider submits the original claim.
- If this provider wants to adjust the original claim, then he or she submits a void of the original claim and then submits a new original claim.
- The void record will have the same original claim number as the original claim.
- There is no link between the original claim and the resubmitted replacement claim.

Table 7. Fee-for-service Medicaid provider-initiated claim adjustment example

BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	TOT_MDCD_PD_AMT
111100000001	201810111111	NULL	0	20190328	125.45	125.45
111100000001	201810111111	201810222222	1	20190517	0.00	0.00
111100000001	201810333333	NULL	0	20190525	150.00	150.00

C. State-Initiated Adjustment

A claim adjustment initiated by the Illinois can be a partial adjustment or a recoupment. For these partial adjustments or recoupments, no single record within the claim family can be considered a final action claim. As a result, the algorithm classifies all claims in the family as final action, if the last claim in the claim family is something other than a void or denied claim.

1. State-initiated partial adjustment

A partial adjustment claim will have the same original claim number as the original claim that it is adjusting. The original claim is populated with all of the data originally submitted by the provider. However, subsequent adjustment claims will not carry forward the values originally reported by the provider for all of the data elements. Only the data elements that change will be populated on the subsequent adjustment claims. As an example, if an original claim had a billed amount of $5,000 and that was unchanged with the adjustment, then the adjustment record would have a null value recorded for the billed amount.

The data elements in a claim header and in a claim line that can potentially change during a partial adjustment are listed in Table 8.

Table 8. Variables that can change during partial adjustments and recoupments

Data Elements in IP Claim Header Segment
CLM_TYPE_CD
TOT_BILL_AMT
TOT_ALOWD_AMT
TOT_MDCD_PD_AMT
TOT_COPAY_AMT
TOT_MDCR_DDCTBL_AMT
TOT_MDCR_COINSRNC_AMT
TOT_TPL_AMT
TOT_OTHR_INSRNC_AMT
SRVC_TRKNG_TYPE_CD
SRVC_TRKNG_PYMT_AMT
Data Elements in the IP Claim Line Segment
SRVC_BGNNG_DT
ALOWD_AMT
TOT_TPL_AMT
MDCD_PD_AMT
OTHR_INSRNC_AMT
Data Elements in OT Claim Header Segment
TOT_BILL_AMT
TOT_ALOWD_AMT
TOT_MDCD_PD_AMT
TOT_COPAY_AMT
TOT_MDCR_DDCTBL_AMT
TOT_MDCR_COINSRNC_AMT
TOT_TPL_AMT
TOT_OTHR_INSRNC_AMT
SRVC_TRKNG_TYPE_CD
SRVC_TRKNG_PYMT_AMT

Data Elements in the OT Claim Line Segment
BILL_AMT
ALOWD_AMT
COPAY_AMT
TPL_AMT
MDCD_PD_AMT
MDCD_PD_AMT
OTHR_INSRNC_AMT

In any file type, partial adjustment claims can be debit adjustments or credit adjustments. For debit adjustments, Illinois was using the adjustment indicator value 4, and for credit adjustments, it was using adjustment indicator value 3. Since '3' is no longer a valid value, the state is now using '0' for credit adjustments.

Tables 9 and 10 show examples of how different types of adjustments would be captured in Illinois' TAF data:

- Table 9 shows an original claim for which the state initiated a debit and then a credit adjustment
- Table 10 shows the same sequence as Table 9, but with the alternative adjustment indicator values after Illinois stopped using a value of '3'

Table 9. Fee-for-service Medicaid original claim with debit and credit adjustments, example 1

BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	TOT_MDCD_PD_AMT
111100000001	201810111111	NULL	0	20190328	5200.00	3200.45
111100000001	201810111111	201810222222	4	20190415	NULL	650.00
111100000001	201810111111	201810333333	3	20190425	NULL	-250.00

Table 10. Fee-for-service Medicaid original claim with debit and credit adjustments, example 2

BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	TOT_MDCD_PD_AMT
111100000001	201810111112	NULL	0	20190328	6500.00	4500.00
111100000001	201810111112	201810222222	4	20190415	NULL	350.00
111100000001	201810111112	201810333333	0	20190425	NULL	-175.00

2. State-initiated void

Table 11 shows an example of how Illinois creates void transactions.

Table 11. Fee-for-service Medicaid original and void claims

BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	TOT_MDCD_PD_AMT
111100000001	201810111119	NULL	0	20190328	6500.00	4500.00
111100000001	201810111119	201810222222	1	20190415	0.00	0.00

3. State-initiated recoupment

Table 12 shows an example of how Illinois creates recoupment transactions.

Table 12. Fee-for-service Medicaid transactions for recoupment because of overpayment to provider

Record #	BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	TOT_MDCD_PD_AMT
1	111100000001	201810011111	NULL	0	20190328	6500.00	6500.00
2	111100000001	201810022222	NULL	0	20190415	750.00	750.00
3	111100000001	201810022222	201810033333	0	20190415	NULL	-500.00
4	111100000001	201810044444	NULL	0	20190525	600.00	600.00
5	111100000001	201810044444	201810055555	0	20190525	NULL	-300.00
6	111100000001	201810066666	NULL	0	20190531	500.00	500.00
7	111100000001	201810066666	201810077777	0	20190531	NULL	-200.00

The sequence captured in these records is:

- Record 1 - A provider submits a claim for $6500, and Illinois adjudicates it and agrees with the amount of $6500. The MMIS determines that there was an overpayment of $1000 to the provider, and that $1000 will be recouped from future payments to provider.

  > ***Note:***
  > *In T-MSIS, the state does not report the $1000 credit because the state reports how the overpayment is offset against each subsequent payment to the provider (refer to records 3, 5, and 7 in the table). Reporting both the $1000 credit because of the overpayment and the actual recoupment to T-MSIS would result in redundant credit amounts.*

- Record 2 - The provider submits a claim for $750, and the state adjudicates the transaction and agrees with the amount of $750. In T-MSIS, it will be reported as a claim record for $750.
- Record 3 - Because this provider owes the state $1,000, the MMIS recoups some of the amount from the payment to the provider and decides to take $500 out of the $750. This record will therefore have a net amount of $250.

  > ***Note:***
  > *Record 3 is an adjustment of Record 2. In T-MSIS, if data users need to know the final payment of a claim, then they must get the sum of the payments in Records 2 3; i.e., the net amount of $250.*

- Record 4 - The provider submits a claim for $600, the state adjudicates the transaction and agrees with the amount of $600. In T-MSIS, it will be reported as a claim record for $600.
- Record 5 - Because this provider still owes the state $500, the MMIS recoups some of it from the payment to the provider and decides to take $300 out of the $600. This record will therefore have a net amount of $300.

  > ***Note:***
  > *Record 5 is an adjustment of Record 4. In T-MSIS, if data users need to know the final*

> *payment of the claim, then they must get the sum of the payments in Records 4 and 5; i.e., the net amount of $300.*

- Record 6 - The provider submits a claim for $500, and Illinois adjudicates the transaction and agrees with the amount of $500. In T-MSIS, it will be reported as a claim record for $500.
- Record 7 - Because this provider still owes the state $200, the MMIS recoups some of it from the payment to the provider and decides to take $200 out of the $500. This record will therefore have a net amount of $300.

> ***Note:***
> *Record 7 is an adjustment of Record 6. In T-MSIS, if users need to know the final payment of the claim, they must get the sum of the payments in Record 6 and 7; i.e., the net amount of $300.*

4. State-initiated service tracking payments

Service tracking payments (also known as gross adjustments) represent lump-sum payments to, or recoupments from, providers which are not directly associated with any single Medicaid or CHIP beneficiary. Service tracking payments are distinguished from other claims by the type of claim. All service tracking claims are reported by Illinois with CLM_TYPE_CD '4', 'D', 'X', and 'Y'. CLM_TYPE_CD 'Y' is supposed to be used by states to identify beneficiary-specific supplemental payments but Illinois had been exclusively using it inappropriately to report lump-sum payments that are not associated with any single Medicaid or CHIP beneficiary. Most of Illinois' service tracking payments have adjustment indicator '5' or '6' but a small percentage have adjustment indicator '0' and '4'. All service tracking payments should be handled in the same way, regardless of the adjustment indicator.

As shown in Table 13, some credit gross adjustments reported by Illinois may have the same original claim number as another claim, but original claim number must always be ignored on all service tracking payments submitted by Illinois, including credit gross adjustments. Only the adjustment claim number should be used to identify distinct service tracking payments. A service tracking payment is never actually associated with any other transaction. As shown in Table 14, debit gross adjustments reported by the state are naturally grouped only into single-claim families but like with credit gross adjustments, the original claim number on debit gross adjustments should be ignored.

Illinois' credit gross adjustments typically have negative dollar amounts, and the state's debit gross adjustments typically have positive dollar amounts. Because credit gross adjustments and debit gross adjustments are types of service tracking payments, the amount paid or recouped on them is expected to be found in the service tracking payment amount, rather than in the total Medicaid paid amount, but users should be aware that it may appear in either field. The service tracking payment amount is only supposed to be populated on service tracking claims and not on other types of claims but Illinois sometimes inappropriately reported the payment amount in the service tracking payment amount on claims that are not service tracking payments. Each credit and debit gross adjustment should be interpreted as a separate and distinct transaction from all other transactions. One gross adjustment is never actually directly related to any other gross adjustment.

Table 13. Medicaid service tracking payment credit gross adjustments

BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	SRVC_TRKNG_PYMT_AMT
111100000001	201810900000000	620000100	5	20190328	0.00	-50.00
111100000001	201811200000011	620000200	5	20190415	0.00	-75.00
111100000001	201811200000011	620000300	5	20190430	0.00	-100.00

Note: Ignore the original claim number on all credit gross adjustments.

Table 14. Medicaid service tracking payment debit gross adjustments

BLG_PRVDR_NUM	ORGNL_CLM_NUM	ADJSTMT_CLM_NUM	ADJSTMT_IND	ADJDCTN_DT	TOT_BILL_AMT	SRVC_TRKNG_PYMT_AMT
111100000001	201810700000022	620000022	6	20190328	0.00	100.00
111100000001	201810700000033	620000033	6	20190415	0.00	450.00

Note: Ignore the original claim number on all debit gross adjustments.

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Sujata Chowdhury[1], Stephen Kuncaitis[2], and Jeffrey Collier[3]. "How to Use Illinois Claims Data." Baltimore, MD: CMS, 2019.

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