Timely Filing Claim Submittal for Non-Institutional Providers

- In accordance with Public Act 097-0689, claims received with dates of service on or after July 1, 2012, are subject to a timely filing deadline of 180 days from date of service, with certain exceptions as outlined below.

- Timely filing deadlines apply to both initial and re-submitted claims.

- For claims received on and after December 15, 2021, the Department will no longer accept paper claims or attachments in accordance with the November 24, 2021 provider notice. Please reference the notice for detailed instructions regarding submission of electronic attachments. The Department has developed a process that allows providers to utilize the Medical Electronic Data Interchange (MEDI) System for electronic claim submission and uploading PDF attachments. If providers submit claims in a format other than MEDI, providers may use the Attachment Upload Portal.

- Except for claims that are received by the Department and immediately returned to the provider as being unacceptable for processing, all claims received are assigned a unique Document Control Number (DCN) and subsequently processed. The DCN consists of the date the claim was received by the Department (displayed as a Julian date) plus an individual number to identify the specific claim. A Julian Date Calendar is provided in General Appendix 1 of the Chapter 100 handbook.

- Following are exceptions to the 180-day timely filing requirement, as well as billing instructions specific to each. Requests for timely filing overrides for any of the following exceptions require a manual override and must be submitted with electronic attachments utilizing one of the above submission options.

    - **Claims received from a provider operated by a unit of local government with a population exceeding 3,000,000 when local government funds finance federal participation for claims payment** - subject to a timely filing deadline of 12 months from date of service. The 12-month deadline extends to any of the exceptions below that indicate a 180-day extension for all other providers. Timeliness for replacement claims, or a void & rebill transaction, is the same as that indicated below.

    - **Medicare crossovers (Medicare payable claims)** - subject to a timely filing deadline of 2 years from the date of service. Claims must be submitted electronically.

    - **Medicare denied claims** - subject to a timely filing deadline of 2 years from the date of service. Electronically attach the EOMB showing the HIPAA compliant denial reason/remark codes, as well as the HFS 1624 Override Request Form stating the reason for the override.

- **Durable medical equipment and supplies (DME) identified on the DME fee schedule as not covered by Medicare** - subject to a 180 day timely filing requirement and must be submitted to the department within 180 days from the date of service. DME items that are coved by Medicare in certain situations should be submitted to Medicare and the Medicare timely filing guidelines above for Medicare payable claims would apply.
- **New provider enrollment, provider re-enrollment, addition of a new category of service, or addition of an alternate payee** - the 180-day period shall begin with the date the enrollment or update was entered on the provider file by the IMPACT Provider Enrollment Services unit. Electronically attach the HFS 1624, Override Request Form, stating the reason for the override with the electronic claim.
- **Retroactive recipient eligibility** – 180 days from the department's system update, which may be viewed on MEDI at www.myhfs.illinois.gov when verifying eligibility. Please ensure eligibility verification is for the date of service and not the current date or a date range. Electronically attach the HFS 1624, Override Request Form, stating the reason for the override with the electronic claim.
- **Replacement or Void/Rebill of an entire claim or single service line** – The department will accept electronic transactions submitted through MEDI or via 837P files to void or replace a paid claim, or a claim that is pending to pay, if submitted within 12 months from the original paid voucher date. Please note the replacement and void claim processes are not applicable to denied claims.
  - **Replacement claims** – To replace a single service line or entire claim, enter Claim Frequency "7". Detailed instructions on how to replace a claim electronically can be found in the Chapter 300, 837P Companion Guide. **This method is preferred as it requires no manual override**.
  - **Void & Re-bill** – This process involves two steps, both of which must be completed electronically. Please refer only to step #1 for a void with no re-bill.
    1. To electronically void a single service line, or an entire claim, enter Claim Frequency/Bill Type '8'. Detailed instructions on how to void a claim electronically can be found in the Chapter 300, 837P Companion Guide.
    2. Following completion of the void, a new original claim must be submitted electronically using Claim Frequency/Bill Type '1' and will only be considered timely if received within 90 days of the void DCN. Please note a manual override may be required if the re-submission date would otherwise be considered past timely. If manual time override is required, electronically attach the HFS 1624, Override Request Form, stating the reason for the time override request.

- **For void or replacement claims the following data elements must match the original claim:**
    - Document Control Number - The 17-digit DCN from the original, paid claim is required. Using the 12-digit DCN from the paper remit:
        - Add '201' to the beginning of that 12-digit DCN
        - Add **either** the 2-digit section number to void or replace a single service line, **or** '00' to void or replace an entire claim, to the end of that 15-digit number.
    - Provider NPI, or for atypical providers the HFS Provider Number
    - Recipient Identification Number

- **Third Party Liability (TPL)** - Claims must be submitted to the department within 180 days following final adjudication by the TPL source(s). Claims must be submitted electronically with TPL fields completed. A TPL code directory and list of accepted TPL status codes may be found on the Provider Handbooks webpage. Timely submission will be calculated systematically from the TPL adjudication date.

- **Primary TPL Recoupment –** Claims must be submitted within 180 days from the date of the recoupment notification letter. Upload an electronic attachment consisting of a copy of the primary TPL recoupment notification letter and the HFS 1624, Override Request Form, stating the reason for the override with the electronic claim.

- **Split bill** – Claims must be submitted to the department within 180 days from the date on the HFS 2432 (Split Billing Transmittal/Spenddown Form). Electronically attach the HFS 2432 with the HFS 1624, Override Request Form, stating the reason for the override request. TPL fields must be completed when applicable.

- **Prior/Post Approval** – Claims must be submitted to the department within 180 days from the date of the prior/post approval date. Electronically attach the HFS 1624, Override Request Form, stating the reason for the override with the electronic claim.

- **Errors attributable to the Department or any of its claims processing intermediaries that results in an inability to receive, process or adjudicate a claim** – the180-day period shall not begin until the provider has been notified of the error and/or error resolution date. For override information specific to each situation please contact a billing consultant at 877-782-5565.