TIMELY FILING OVERRIDE Q & A

1. **Q:** Customer presents to provider with Illinois Medicaid card and indicates care is related to a workers' compensation case. Can the provider file a claim to the workers' compensation carrier and to HFS, and then refund to HFS at whatever point there is a workers' compensation settlement?

   A: No. A provider must decide up front whether to submit the claim to HFS or submit to the workers' compensation carrier. Once the claim is submitted to HFS, the provider has agreed to accept the customer as Medicaid and, therefore, agrees that payment from Medicaid will be accepted as payment in full. Please refer to Chapter 100, Section 101.3. Providers should be aware if they choose up front to wait for reimbursement from the worker's compensation claim and that decision does not work in their favor, they may not seek reimbursement from HFS for any date(s) of service past timely filing limits by requesting a time override. This scenario does not qualify for timely filing override.

2. **Q:** Customer presents to provider with Illinois Medicaid card and indicates care is related to an automobile accident/personal liability case. Can provider file a claim to HFS, and then refund to HFS at whatever point there is a liability settlement and pursue collection from the settlement?

   A: No. A provider must decide up front whether to submit the claim to HFS or wait to pursue collection from a potential settlement. Once the claim is submitted to HFS, the provider has agreed to accept the customer as Medicaid and, therefore, agrees that payment from Medicaid will be accepted as payment in full. Please refer to Chapter 100, Section 101.3. Providers should be aware if they choose up front to wait for reimbursement from a potential settlement and that decision does not work in their favor, they may not seek reimbursement from HFS for any date(s) of service past timely filing limits by requesting a time override. This scenario does not qualify for timely filing override.

3. **Q:** In either a workers' compensation or a personal liability settlement case, if provider elects to not bill HFS until after the settlement, will HFS override timely filing, even though it may be several years until settlement is reached?

   A: No. See #'s 1 and 2 above.

4. **Q:** Customer presented to provider with Illinois Medicaid card and stated he had no other coverage. The provider billed HFS, but HFS record still showed TPL information on file and rejected as T21, Third Party Liability. Provider waited for customer to contact caseworker to make a change on the TPL screen. Will HFS override timely filing?

A: The provider has the responsibility of checking eligibility at the time of service. At that point, the provider should ask the customer about the TPL information as it appears on the Medicaid file, then code the TPL fields of the claim accordingly (patient states he/she does not have TPL or that the service is not covered). HFS will not override timely filing for this situation. If HFS rejects a claim as T21, Third Party Liability, and the provider did not know prior to rendering the service that HFS records show TPL for the patient, the provider should contact the patient. If the patient states that he/she does not have TPL or that the service is not covered, the provider should resubmit the claim to HFS within timely filing limits and code the TPL fields of the claim accordingly. A list of TPL status codes may be found on the Provider Handbooks webpage.

5. **Q:** Customer has a Medicare Advantage Plan. For timely filing purposes, do we consider this plan the same as a regular Medicare claim?

   A: Yes. The timely filing deadline is two (2) years from the date of service when the participant has Medicare or a Medicare Advantage Plan as primary.

6. **Q:** If HFS pays a claim at $0 secondary to a primary TPL/Medicare that paid more than the HFS state max, but the TPL later recoups payment for some reason, does the provider submit a void of the dept's $0 pay and then resubmit with TPL status code changed to the new status code and date as well as attaching the TPL recoup notification letter?

   A: Yes. The $0 payment must first be voided. The claim may then be re-submitted with a cover letter requesting manual time override. The claim must be submitted with an attachment consisting of a copy of the TPL recoupment letter and any applicable service documentation.

7. **Q:** If HFS will not override timely filing what happens?

   A: Claims submitted with a timely filing override request that are determined not to meet timely filing exception criteria will be routed into processing in order to document their receipt. Remittance advice will provide documentation to the provider that the claim rejected for timely filing. If a provider wishes to inquire why the claim did not qualify for the requested time override they should contact a billing consultant at (877) 782-5565.

8. **Q:** A customer was not enrolled in an MCO when admitted to the hospital but was later enrolled in an MCO during the inpatient stay and the claim rejects with the message 'Recipient in MCO' or 'Recipient Has Prepaid Full-Service Plan'. Will 180-day timely filing guidelines apply to this claim?

   A: Yes. Providers will have 180 days from the date of service to submit the claim to HFS with a request for manual override. However, if the provider billed the MCO and received a

denial, the department will allow 180 days from the adjudication date on the EOB received from the MCO.

9. **Q:** Hospital billing HFS policy states that two claims are to be submitted when an ER visit is rendered on one date and the inpatient admission occurs on the next calendar date. This should be viewed as one incident of care. Medicare policy is that any services rendered within a 72-hour window are to be bundled and reported on one claim. Hospitals typically do not bill the ER visit until the patient is discharged from inpatient status. If a customer has an ER visit followed by a lengthy inpatient stay, the 180 days following the ER visit may expire before the discharge date. In such a case, will HFS allow a timely filing override on a professional claim submitted by a practitioner for the ER visit?

   A. No, timely filing for the practitioner's professional/837P claim remains 180 days following the date of service. If the claim is a Medicare crossover or Medicare denied service, the timely filing period remains at 2 years from the date of service. If the claim does not involve Medicare, the provider must bill the ER service within 180 days of the date of service, regardless of the length of the inpatient stay. In some cases, this may mean that the provider must bill the ER visit prior to the discharge from the inpatient stay.