Timely Filing Guidelines for Long Term Care Providers

Submittal of claims must be in accordance with 89 Ill. Adm. Code 140.20. Claims for Long Term Care Providers are subject to a timely filing deadline of 180 days from the statement through date of the claim. Timely filing applies to both initial and re-submitted claims following prior rejection. Timely filing deadlines are not extended based on a previously rejected claim.

Exceptions to the 180 day timely filing requirement

- For individuals with pending eligibility and/or Long Term Care admission transactions during the dates of service, the timely filing deadline is 180 days from the Department of Human Services caseworker's initial processing of the admission into the HFS payment system. Long Term Care Providers can submit a LTC Inquiry transaction through LTC links in MEDI to view admissions that have been processed. Providers are notified of processed admissions via the HFS 2449A Daily Transaction Report.
- For Medicare primary claims, the timely filing deadline is 24 months from the statement through date of the claim adjudicated by Medicare or Medicare Advantage Plan.
- For claims in which the Department is not the primary payer, the timely filing deadline is 180 days from the adjudication date of a payment made by a primary payer other than Medicare or a Medicare Advantage Plan.
- For a service period for which a previous claim was voided, the void transaction DCN must be within 12 months of the original paid voucher date for the resubmitted claim to be considered for payment. The resubmission of a claim for the service period previously voided must be received within 90 days from the date of the remittance advice reporting the posting of the void. Please note that the purpose of voiding and rebilling a previously paid claim is to correct errors on the claim (e.g. incorrect number of leave of absence days billed, change in the number of Medicare covered days, etc.) and not for the purpose of billing additional Medicaid covered days.

Due to the timely filing requirements, the Bureau of Long Term Care recommends that providers follow up on claim submissions within three business days from the claim submittal. Providers can verify the acceptance of submitted claims via the Claim Status Inquiry function in the MEDI Internet Electronic Claims Application. Please contact the Bureau of Long Term Care at 217-782-0545 or 844-528-8444 toll free or for any billing questions you may have.