Long Term Care Provider
Submission of Claim Void and Resubmission of Replacement Claim Requirements

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Effective with dates of service on and after December 1, 2016, coding corrections to previously adjudicated payable Long Term Care (LTC) claims will require the provider to void the original claim via the submittal of an HFS 2249 "*Adjustment (Hospital)"* form. Once the initial claim is voided, a replacement claim with corrected information must be electronically submitted to the Department of Healthcare and Family Services (HFS) to facilitate a correction of payment.

HFS currently does not have the capability to electronically accept a Type of Bill Frequency Code "7" - Replacement of Prior Claim, or a Type of Bill Frequency Code "8" - Void/Cancel of Prior Claim. Therefore, the provider must request the incorrectly paid claim be voided by faxing an Adjustment (Hospital) form HFS 2249 to the Bureau of Long Term Care at (217) 557-5061. The Adjustment (Hospital) form HFS 2249 can be obtained on the HFS website under the Medical Provider Information Center list of Medical forms or by following the link in this notice.

Attached is an example of a completed form HFS 2249 with the required data elements entered. The required data elements identify the specific claim the provider wishes to void and can be obtained from the remittance advice that reported the claim as paid. Submitted HFS 2249 forms received by the Bureau of Long Term Care must contain:

- Item 2 - Provider Name,
- Item 4 - Provider Number,
- Item 6 - Voucher Number,
- Item 7 - Document Control Number,
- Item 9 - Date of Service (Claim Begin Date),
- Item 11 - Recipient Name,
- Item 12 - Recipient Number,
- Item 14 - Reason Adjustment Requested,
- Item 15 – Provider Signature, and
- Item 16 – Signature Date

HFS will process the void request within five working days of receipt. The provider will be notified of the completed void transaction via the remittance advice. Providers may also perform a Claim Status inquiry through the IEC links to see if the void has been processed. After the void has been completed by the Department, the provider must electronically submit a new claim for the applicable service period to receive the corrected payment.

The Department will process void requests for any date of service with a voucher date within the previous five years. However, for any rebilled service period to be eligible for payment consideration by the Department, a claim for a service period for which a previous claim was voided must be received within the latter of:

1. 180 days from the statement through date of the claim, or
2. 180 days from the Department of Human Services caseworker's initial processing date of the admission into the HFS payment system; or
3. 90 days from the date of the remittance advice reporting the posting of the void for claims voided within 12 months of the voucher date of the original paid claim.

Claims that do not meet this requirement for timely submittal will be rejected.

NOTE: 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.

Additional Notes:

The Department will systematically initiate a void of a previously adjudicated Long Term Care claim if an inpatient claim (such as hospitalization) is received with an overlapping date of service. This will most likely occur when the LTC provider does not code a hospital leave of absence to coincide with the hospital inpatient claim. The provider will be notified of the void via a remittance advice and may also perform a Claim Status inquiry through the IEC links. If a claim is systematically voided by the Department, the provider must electronically submit a new claim for the applicable service period to receive a corrected payment. To be eligible for payment consideration by the Department, a claim for a service period for which a previous claim was voided must be received within the timely filing requirements listed above.

Adjustments for retroactive rate changes and patient credit changes will be systematically processed by HFS. Providers are **not** required to void and resubmit claims to receive adjusted payments for rate changes and patient credit changes. Providers should continue to submit all recipient income changes timely through an EDI vendor or the MEDI LTC income change links so that DHS caseworkers can update the residents' patient credit amounts. Questions regarding the status of submitted or completed income changes should continue to be addressed through the appropriate DHS office that handles the facility's LTC cases.