Timely Filing Claim Submittal for Non-Institutional Providers

➢ Non-Institutional claims are subject to a timely filing deadline of 180 days from date of service.

➢ Timely filing applies to both initial and re-submitted claims.

➢ Durable medical equipment and supplies (DME) identified on the DME fee schedule as not covered by Medicare are 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 covered by Medicare in certain situations should be submitted to Medicare and the Medicare timely filing guidelines listed for Medicare payable claims would apply.

➢ Claims addressed to a HFS post office box are received M-F between 8:30 am and 5:00 pm at a distribution center for further sorting and delivery to specified locations/units. Upon arrival at the Bureau of Claims Processing, paper claims are assigned a document control number (DCN) within 24 hours. The first 7 numbers of the DCN represent the Julian date the claim was received. If the claim must be routed to a different unit for special handling, the paper claim will be physically date stamped on the day it is received in the unit. Timeliness of override requests received in the Bureau of Professional and Ancillary Services is determined by the date stamp.

➢ **Timely filing override requests for any exceptions that require a manual override must be submitted with an original paper claim form and any attachments to the following address (unless otherwise noted)**:

> Healthcare and Family Services
> Bureau of Professional and Ancillary Services
> Attn: Billing Consultant
> P.O. Box 19115
> Springfield, Illinois 62794-9115

Exceptions to the 180 day Timely Filing Requirement are as follows:

- **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 exceptions 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 may be submitted electronically or on the paper HFS 3797 to the following address:
  > HFS
  > P.O. Box 19109
  > Springfield, IL 62794

- **Medicare denied claims** – subject to a timely filing deadline of 2 years from the date of service. Submit a paper HFS 2360, HFS 1443, HFS 2209, HFS 2210, or HFS 2211 with the EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach Form HFS1624, Override Request form, stating the reason for the override.

- **New provider enrollment, provider re-enrollment, addition of a new specialty/sub-specialty, or addition of an alternate payee** – *applies only to those claims that could not be billed until the enrollment, re-enrollment, addition of a new specialty/sub-specialty, or payee addition was complete*. The 180 day period shall begin with the date the enrollment, re-enrollment, or update was recorded on the provider file. Attach form HFS 1624, Override Request, stating the reason for the request to a paper claim form. Upon receipt of claims with an override request, HFS staff will verify that the claim(s) could not have been billed without the change to the provider file. Requests for override due to a provider file change must be requested within 180 days of a claim rejecting due to the discrepancy.

- **Retroactive Participant eligibility** – 180 days from the Department's system update viewed on MEDI when verifying eligibility. Please ensure eligibility verification is for the date of service and not current date or date range. Attach a HFS 1624, Override Request Form, stating the reason for the override to a paper claim form.

- **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 (includes claims paid at $0), or a claim that is pending to pay, if submitted within 12 months from the original paid voucher date.

  NOTE: The functionality of allowing replacement claims and claims to be re-billed following a void is for the purpose of correcting errors on previously submitted and paid claims (e.g. incorrect provider number, incorrect date of service, incorrect procedure code, etc.) and NOT for the purpose of billing additional services.

  - **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. The void portion may be completed electronically or on paper. 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 "8". Detailed instructions on how to void a claim electronically can be found in the Chapter 300, 837P Companion Guide. A paper void may be completed by submitting a NIPS Adjustment Form HFS 2292. Instructions on how to complete the form are located in Chapter 100, Appendices.
    2. Following completion of the void, a new original claim must be submitted within 90 days of the void DCN and may require manual override. If manual override is required, attach form HFS 1624, Override Request Form, stating the reason for override to a paper claim. Community Mental Health Providers (provider type 036) who do not have a paper billing option should contact a billing consultant for override instructions.

  NOTE: 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 the 15-digit number.
  - Provider NPI, or for atypical providers the HFS Provider Number.
  - Recipient Identification Number.

- **TPL** – Claims must be submitted to the Department within 180 days after the final adjudication by the primary payer. Claims may be submitted electronically or on paper and must have TPL fields completed. Timely submission will be calculated systematically based on the TPL adjudication date. For this reason, no override request is necessary.

- **Split bill** – Claims must be submitted to the Department within 180 days from the date on the HFS 2432 (Split Billing Transmittal/Spenddown Form). Attach the HFS 2432 with form HFS 1624, Override Request Form, stating the reason for the override to a paper claim form. TPL fields must be completed.

- **Primary TPL Recoupment** – Claims must be submitted within 180 days from the date of the recoupment notification letter. Attach a copy of the recoupment notification letter and form HFS 1624, Override Request Form, stating the reason for the override to a paper claim form. TPL fields on the paper claim must be completed when applicable.

- **Local Education Agencies (LEAs)** – Claims must be submitted to the Department within 18 months from date of service. Claims may be submitted electronically or on the paper HFS 1443.

- **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 by either the date on the paper voucher/remittance advice or the fix date on the Claims Processing System Issues webpage. For override information refer to the rebilling instructions posted on the webpage, or contact a billing consultant at 877-782-5565 in the absence of notification on the webpage.