TIMELY FILING OVERRIDE Q & A

1. **Q:** Client presents to provider with Illinois Medicaid card and also states his case is Workers' Compensation. Can the provider file a claim to Workers' Compensation 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 client as Medicaid and, therefore, agrees that payment from Medicaid will be accepted as payment in full (Chapter 100, Section 101.1).

2. **Q:** Client presents to provider with Illinois Medicaid card and also states case is 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 client as Medicaid and, therefore, agrees that payment from Medicaid will be accepted as payment in full (Chapter 100, Section 101.1).

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:** Client 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 client 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 client 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 cannot override timely filing for this situation. If HFS rejects a claim as T21, Third Party Liability,

and the provider did not know prior to providing 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 and code the TPL fields of the claim accordingly (Chapter A-200, Appendix 1).

5. **Q:** Client has a Medicare Managed Care Private-Fee-For-Service (PFFS) plan. For timely filing purposes, do we consider this plan the same as a regular Medicare claim?

   A: Yes.

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. These must be submitted with a cover letter requesting the override, an original clean paper claim form and any attachments and mailed to a practitioner billing consultant.

7. **Q:** If HFS will not override timely filing, will HFS return the claim to the provider or put the claim into processing and allow it to reject as past timely filing?

   A: The department will document the date the claim was received and notify the provider that the claim is not eligible for timely filing override. Claims will be processed so a DCN documents the claim's receipt, the provider will receive a rejection for timely filing, and the provider will receive a form letter explaining that claims received are not eligible for timely filing override and noting the reason for ineligibility.

8. **Q:** A client who was not in an MCO when admitted to the hospital but entered an MCO during the inpatient stay and the claim rejected with error code R39, 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 services to submit the claim. However, if the provider billed the MCO and received a denial, the department will allow 180 days from the adjudication date on the EOB.

9. **Q:** (UB) 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 client 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 for the ER visit?

A. No, timely filing for the outpatient 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 following 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.