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 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 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 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.

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 date of service, or
2. 180 days from the Department of Human Services caseworker’s initial processing of the admission into the HFS payment system; or
3. 90 days from the date of the remittance advice reporting the void.

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

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 continue to 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.

State of Illinois
Illinois Department of Healthcare and Family Services

ADJUSTMENT (HOSPITAL)

AAH

1. DOCUMENT CONTROL NUMBER (Dept Use Only)

61

2. PROVIDER NAME, ADDRESS, CITY,STATE, ZIP

ACME LTC TEST

3. PAYEE NUMBER

4. PROVIDER NUMBER

123456789003

5. PROVIDER NPI NUMBER

ADJUSTMENT TO

6. VOUCHER NUMBER

70050510

7. DOCUMENT CONTROL NUMBER

700145212891

8. COS

9. DATE OF SERVICE

1 2 0 1 1 6

10. PROVIDER REFERENCE NUMBER

11. RECIPIENT NAME (FIRST, MI, LAST)

JANE DOE

12. RECIPIENT NUMBER

123456789

13. DATE OF BIRTH

FOR PROVIDER USE ONLY

14. REASON ADJUSTMENT REQUESTED

EXAMPLES OF REASON FOR ADJUSTMENT:
1. MEDICARE COVERAGE ADJUSTED RETROACTIVLY
2. CORRECTION OF LEAVE OF ABSENCE DAYS ORIGINALLY REPORTED
3.TPL PAYMENT RECEIVED OR ADJUSTED FOR SERVICE PERIOD

Completion Mandatory, 305 ILCS 5/1-1 et seq. Failure to complete may result in the department taking unfavorable action. Form has been approved by the Forms Management Center.

This is to certify that the information above is true, accurate and complete

15. PROVIDER SIGNATURE

02/10/16

16. DATE

FOR ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

17. PROCESS TYPE

18. CAT SERVICE

19. CREDIT AMT

20. DEBIT AMT

21. REASON CODE

22. REASON ADJUSTMENT MADE OR DENIED

23. EMPLOYEE

24. DATE

25. AUTHORIZED HFS SIGNATURE