**Section 140.20 Submittal of Claims**

a) When claims for payment are submitted to the Department, providers shall:

1) Use Department designated billing forms or electronic format for submittal of charges; and

2) Certify that:

A) They have personally rendered the services and provided the items for which charges are being made;

B) Payment has not been received, or that only partial payment has been received;

C) The charge made for each item constitutes the complete charge;

D) They have not, and will not, accept additional payment for any item from any person or persons;

E) They will not make additional charges to, nor accept additional payment from, any persons if the charges they present are reduced by the Department to conform to Department standards; and

F) Starting June 1, 2019, in the case of providers of medical equipment, supplies, prosthetic devices and orthotic devices, the provider is accredited by a healthcare accrediting body approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department under Section 140.475(g).

b) Statement of Certification

1) All billing statements shall contain a certification statement that must remain unaltered, and must be legibly signed and dated in ink by the provider, his or her designated alternate payee, or his or her authorized representative. A rubber stamp or facsimile signature is not acceptable.

2) An "authorized representative" may only be a trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. The representative must be specifically designated and must sign the provider's name and his or her own initials on each certification statement.

3) An alternate payee must be specifically designated by the provider and must sign the provider's name and alternate payee's authorized representative's initials on each certification statement.

c) Effective July 1, 2012, to be eligible for payment consideration, a provider's vendor-payment claim or bill, either as an initial or resubmitted claim following prior rejection, that can be processed without obtaining additional information from the provider of the service or from a third party, must be received by the Department, or its fiscal intermediary, no later than 180 days after the date on which medical goods or services were provided, with the following exceptions:

1) The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than 24 months after the date on which medical goods or services were provided.

2) In the case of a provider whose enrollment is in process by the Department, the 180-day period shall not begin until the date on the written notice from the Department that the provider enrollment is complete.

3) In the case of errors attributable to the Department or any of its claims processing intermediaries that result in an inability to receive, process or adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.

4) In the case of a provider for whom the Department initiates the monthly billing process.

5) For claims for rendered during a period for which a recipient received retroactive eligibility, claims must be filed within 180 days after the Department determines the applicant is eligible.

6) For claims for which the Department is not the primary payer, claims must be submitted to the Department within 180 days after the final adjudication by the primary payer.

A) For purpose of this subsection (c)(6), a primary payer is a payer that can reasonably be expected to make payments within 120 days after the date of service; for example, other medical insurance or a group health plan, when the patient is the insured party. Primary payer does not include payers who are not reasonably expected to pay within 120 days; for example, liability insurance and workers' compensation, when the patient is not the insured party.

B) During the 180 day period beginning November 15, 2014, providers may submit claims and request a time override from the Department for claims with dates of service on and after July 1, 2012 not filed because of the provider's belief that it could file after final adjudication by an insurer when the patient was not the insured party. A provider asking for such a time override shall also provide a copy of the request for time override to the Department's Bureau of Collections, with a written notification to the Bureau indicating the names and addresses of other parties, insurers or attorneys involved in attempting to recover, defend or settle possible damages to the patient that resulted in the services provided. Failure to provide the required information to the Bureau shall result in a denial of the request for time override.

7) In the case of long term care facilities, admission documents shall be submitted as provided in Section 140.513. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, the Department will generate a monthly billing statement (remittance advice) for the services rendered to the admitted Medicaid eligible resident from date of admission through date of discharge.  Any disputes regarding payment for services provided from the date of admission through date of completion of the admission transaction must be submitted to the Department for Payment Review Request (HFS Form 3725) no later than 180 days after the date of completion of the admission transaction.  For any disputes regarding payment for services rendered after the date of completion of the admission transaction, the Payment Review Request must be submitted to the Department within 180 days after the:

A) date of the remittance advice that initially shows the adjudication for the date or dates of service that are disputed;

B) date of the remittance advice that rejects a previously adjudicated claim, if rejection is the basis for the disputed payment; or

C) date of the remittance advice that adjusts a previously adjudicated claim, if the adjustment is the basis for the disputed payment.

8) For hospital inpatient claims, the 180 days is measured from the date of discharge.

9) Per Public Act 98-104, in the case of 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, a claim must be received by the Department or its fiscal intermediary no later than one year after the date on which medical goods or services were provided.

d) Claims that are not submitted and received in compliance with the foregoing requirements will not be eligible for payment under the Department's Medical Assistance Program, and the State shall have no liability for payment of the claim.

(Source: Amended at 42 Ill. Reg. 4829, effective March 1, 2018)