INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Claim Adjustments

Voids and Replacements

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: December 12, 2017	Scheduled update: • Added *Voids and Replacements* as a subtitle to module name • Edited and reorganized text as needed for clarity • Replaced Hewlett Packard Enterprise references with DXC Technology • Added ICN as alternate terminology for Claim ID • Revised language throughout the module to reflect that *void* and *replacement* terminology is not specific to electronic adjustments • Updated the *Introduction* section with definitions of void and replacement • Updated the *Types of Adjustments* section as follows: – Incorporated mass replacements for LTC facility rate adjustments as a type of mass adjustment – Added mass replacements for end-of-month waiver liability as a type of mass adjustment – Added a category for adjustments converted from the previous MMIS – Added a general explanation of region codes • Added region code 57 to the *Check-Related Voids and Replacements* section and defined region code 51 • Added region codes 56, 61, 62, and 63 to the *Non-Check-Related Voids and Replacements* section and defined region code 50	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		• Added region codes 55, 56, and 64 to the *Mass Voids or Replacements* section and defined region code 52 • Added *End-of-Month Adjustments for Waiver Liability* as a subsection under *Mass Voids or Replacements* • Added the *Adjustments Converted from the Previous System* section • Expanded information in the note box about submitting detail-level TPL information in the *Adjustment Submission Procedures* section • Added procedures for tracking electronic adjustments in the *Claim Adjustment Processing and Tracking* section	

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Claim Adjustments: Voids and Replacements

Introduction

Claim adjustments are changes to claim reimbursements that Indiana Health Coverage Programs (IHCP) has made to providers. The *Health Insurance Portability and Accountability Act* (HIPAA) refers to claim adjustment transactions as voids or replacements:

- A *void* results in the full recoupment of the originally paid claim.
- A *replacement* is when a paid claim is reprocessed with the appropriate modifications.

This document provides information about various types of paid claim adjustments. It also highlights general information about submitting nonpharmacy, fee-for-service, paid claim adjustment requests.

> *Note:* *Claim adjustments for members enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise (other than adjustments related to carved-out services) are submitted to and processed by the managed care entity (MCE) with which the member is enrolled. Each MCE establishes and communicates its own criteria for claim adjustments. Questions about claim adjustments for managed care members should be directed to the appropriate MCE. See the IHCP Quick Reference Guide at indianamedicaid.com for MCE contact information. For information about carved-out services, see the Claim Submission and Processing module.*
>
> *DXC Technology handles all IHCP fee-for-service claims, except for pharmacy claims, which are handled by OptumRx. See the Pharmacy Services module for information regarding pharmacy claim adjustments.*

Types of Adjustments

All claim adjustments (voids and replacements) are performed to make changes to a previously paid claim. This section outlines four types of claim adjustments:

- Check-related adjustments
- Non-check-related adjustments
- Mass adjustments, including mass replacements for retroactive rate adjustments for long-term care facilities and end-of-month adjustments for waiver liability
- Adjustments converted from Indiana*AIM* (the previous Medicaid management information system, before the conversion to *Core*MMIS)

When an adjusted claim appears on the Remittance Advice (RA) statement or the 835 transaction, the type of adjustment performed can be identified by the claim's region code, which corresponds to the first two digits of the internal control number (ICN), also known as the Claim ID.

Check-Related Adjustments

A provider can initiate a check-related adjustment (void or replacement) when an excess payment has been made. The provider sends a check in the amount of the excess payment with the adjustment form and appropriate attachments (see the *Adjustment Submission Procedures* section for details).

A check-related adjustment is sometimes called a *refund*, because the provider is returning money to the IHCP. The provider can refund a partial payment on a claim, such as a refund adjustment, or the entire payment on a claim, such as a full claim refund or void.

For example, if the provider billed and was paid for more units of service than were actually performed, the provider refunds only the excess payment. If a provider was paid for services not rendered, the provider refunds the entire payment made on the claim. A check-related adjustment is identified on an RA statement or the 835 transaction with the following region codes (first two digits of the ICN/Claim ID):

- 51 – Check-related replacement, submitted by mail or automatic Surveillance and Utilization Review (SUR) agency, partial replacement
- 57 – Check-related void, submitted by mail or SUR, full recoupment

Non-Check-Related Adjustments

A non-check-related adjustment is a void or replacement initiated by a provider due to an underpayment or overpayment. It does not include a refund check from the provider. The following are the types of non-check-related adjustments:

- *Underpayment adjustment* – If the adjustment was requested because the provider was underpaid, the adjustment is processed based on the adjustment request form and appropriate documentation.
- *Overpayment adjustment* – If the request is to adjust an overpayment, the overpaid amount is deducted from future claim payments through an accounts receivable adjustment.
- *Full claim overpayment* – If the request is to void the claim, the accounts receivable can be set up to recoup the entire amount of the claim.

> *Note: Detailed information about accounts receivable can be found in the Financial Transactions and Remittance Advice module.*

Providers can submit a non-check-related adjustment request for a previously paid claim only when an incorrect or partial payment has been made on the claim, including a claim that incorrectly paid zero dollars.

Providers can initiate a non-check-related adjustment either electronically or by mail, as described in the *Adjustment Submission Procedures* section. A non-check-related adjustment is identified on the RA statement or 835 transaction by the following region codes (first two digits of the adjusted claim's ICN/Claim ID):

- 50 – Noncheck replacement, submitted by mail or SUR, partial replacement
- 56 – Noncheck void, submitted by mail or SUR, full recoupment
- 61 – Replacement submitted electronically, with an attachment or claim note
- 62 – Replacement submitted electronically, without an attachment or claim note
- 63 – Void, submitted electronically

Adjustments for Certain Line-Item Denials

Most line-item denials for paid claims must be billed as a new claim submitted on the correct claim form to the correct claim processing address and cannot be submitted as an adjustment. However, in the case of specific services that must be billed together on one claim form, line-item denials must be processed through the Adjustment Unit. For example, certain transportation services – such as base rate and mileage or waiting time and mileage – must be billed together on the same claim form. In this instance, line-item denials cannot be billed separately. If one of these items was paid and the other was denied, an adjustment would need to be submitted to receive payment for the denied detail. Another example is home health claims that must be billed with the overhead and the encounter on the same claim form.

Nonspecific durable medical equipment (DME) and home medical equipment (HME) procedure codes, or other services billed multiple times for the same date of service but with a different number of units, are denied as duplicate claims and must also be resolved by the Adjustment Unit. Claims billed with multiple dates of service on one detail line, or *span dated,* must be resolved by the Adjustment Unit.

Mass Adjustments

The Family and Social Services Administration (FSSA), HMS, Myers and Stauffer, or DXC can initiate a *mass adjustment* (void or replacement). Mass adjustment requests are applied to change a large number of paid claims at one time. This process can apply to many providers or one provider:

- Positive adjustments, or additional money to the provider, are corrected by additional payment through the regular claim payment process.
- Negative adjustments, or money owed to the IHCP, are recouped through the accounts receivable function and are usually collected through the offset of future claims payments.

Mass adjustments can be used when a system problem caused claims to be paid incorrectly or when a rate for a procedure code changed retroactively. A mass adjustment is identified on the RA statement or the 835 transaction by the following region codes (first two digits of the adjusted claim's ICN/Claim ID):

- 52 – Mass replacement, non-check-related
- 55 – Mass replacement, institutional provider retroactive rate
- 56 – Mass void request (by mail or SUR full recoupments)
- 64 – Waiver liability end-of-month auto-initiated mass replacement

The following subsections provide additional information about the mass adjustments identified by region codes 55 and 64.

Retroactive Rate Adjustments for Long-Term Care Facilities

Myers and Stauffer, LC, is the IHCP rate-setting contractor for long-term care (LTC) facilities. When Myers and Stauffer updates a *per diem* rate for a specific time frame, including retroactive rate adjustments, the new rates are forwarded to the FSSA and DXC. The rates on the IHCP Core Medicaid Management Information System (*Core*MMIS) provider file are updated automatically, and retroactive rate claim adjustments are systematically initiated.

*Core*MMIS reprocesses all claims submitted by the provider for the dates of service affected by the retroactive rate adjustment. Retroactive rate adjustments can result in an increase or decrease in payment, depending on whether the new rate is higher or lower. A retroactive rate adjustment is identified on the RA statement or the 835 transaction with a region code of 55, which means the first two digits of the ICN/Claim ID are 55.

Providers should contact Customer Assistance for questions about retroactive rate adjustments. Contact Myers and Stauffer only for information about rate changes. See the *IHCP Quick Reference Guide* at indianamedicaid.com for contact information.

End-of-Month Adjustments for Waiver Liability

At the end of each month, *Core*MMIS automatically initiates a mass replacement of claims for liability related to home and community-based services (HCBS) waivers or end-stage renal dialysis (ESRD) waiver benefits. This mass replacement is identified on the RA statement or the 835 transaction with a region code of 64, which means the first two digits of the ICN/Claim ID are 64.

Adjustments Converted from the Previous System

When the IHCP converted to the *Core*MMIS claim-processing system, previously submitted claim adjustments were entered into the new systems with the following region codes (first two digits of the adjusted claim's ICN/Claim ID):

- 45 – Fee-for-service adjusted claims converted from former MMIS
- 48 – Fee-for-service voided claims converted from former MMIS

Adjustment Filing Limitations

The IHCP policy on filing limits indicates that claims must be submitted within a year from the date of service. Adjustments may be initiated only when an incorrect or partial payment has been made on a claim.

The Adjustment Unit must receive all paid claim adjustment requests **within 60 days** of notification of the claim's disposition. The date of notification is considered to be the date on the RA. The following rules also apply to filing limitations related to claim adjustments:

- Providers can obtain an extension of the timely filing limit for adjustments under the same circumstances as an initial claim, if adequate documentation is submitted.
- When a payment is made by Medicare, a crossover claim is not subject to the filing limit.
- Medicare-denied services are not considered crossover claims and are not exempt from the filing limit.
- Overpayment adjustment requests are not subject to the timely filing limit. Any overpayment identified by a provider must be returned to the IHCP regardless of the filing limit.
- If a provider is adding a detail to a claim that is being adjusted, proof of timely filing documentation needs to be submitted with the claim.

For additional information about claim-filing limitations, including documentation requirements for filing limit extensions, see the *Claim Submission and Processing* module.

Adjustment Submission Procedures

This section outlines the guidelines for submitting adjustment requests for paid, nonpharmacy, fee-for-service claims. Adjustment requests may be submitted electronically or by mail.

Adjustment requests are considered only for previously paid claims or line items. Refunds to paid claims are considered adjustments; therefore, refunds must comply with these adjustment procedures.

> *Note:* *Many claim types require TPL and Medicare information to be submitted at the detail level. For applicable claim types, providers must submit this detail-level information along with the adjustment request, even if the original claim did not contain detail-level information. Failure to comply with this requirement may result in a full recoupment of the claim. Detail-level TPL and Medicare information can be submitted electronically, along with the electronic void or replacement, or by including a completed IHCP Third-Party Liability (TPL)/Medicare Special Attachment Form with the adjustment request form sent by mail. See the Claim Submission and Processing module for details.*

Submitting Adjustments Electronically

An electronic void or replacement may be performed using the IHCP Provider Healthcare Portal at indianamedicaid.com or submitted via the appropriate 837 claim transaction. See the *Provider Healthcare Portal* module and the *Electronic Data Interchange* module for details.

When submitting electronic replacements, it is important that providers adhere to the 60-day filing limit. However, if the date of service on a replacement claim is more than 12 months prior to the date of submission, providers should submit the replacement via paper to the Adjustment Unit with the appropriate documentation to avoid inadvertent recoupment of the entire claim paid amount. Providers may void a claim electronically without regard to the filing limitation.

Submitting Adjustments by Mail

Paid claim adjustments can be submitted by mail using the following forms, available from the *Forms* page at indianamedicaid.com:

- *CMS-1500, Dental, Crossover B Paid Claim Adjustment Request*
- *UB-04 and Inpatient/Outpatient Crossover Adjustment Request*

For all non-check-related adjustments, the appropriate adjustment request form must be completed as directed in the respective fields. If all relevant information is not completed on the form, the Adjustment Unit returns the non-check-related adjustment request with an explanation of why the adjustment was not processed. The adjustment form must be submitted before an adjustment to a paid claim can occur. Highlights about adjustment forms include the following:

- Each adjustment form has a field titled *Reason for adjustment*, to be completed as follows:
  - Mark *Change TPL amount* if the submitted third-party liability (TPL) information was incorrect.
  - Mark *Change patient deductible amount* if the submitted patient-deductible amount was incorrect.
  - Mark *Offset or refund of entire claim amount* if the entire claim is to be refunded through the offset. The claim type must be marked.
  - Mark *Change information as indicated* in the specified blocks if any of the detail information should be corrected.
  - Mark *Medicare adjustment* if a change is required to a crossover claim. Attach all explanations of Medicare benefits (EOMBs) that apply to the adjustment.
- The ICN/Claim ID of the claim to be adjusted must be included on the adjustment form. If the claim has been previously adjusted, the most recent ICN/Claim ID must be used.
- Submit only one ICN/Claim ID per non-check-related adjustment request.

- To expedite processing, it is recommended that providers attach a copy of the original paid claim and the RA to the adjustment form. For crossover claims, a copy of the EOMB and the IHCP RA are required.
- Each adjustment form has a field titled *Type of adjustment,* to be completed as follows:
  - Mark *Underpayment adjustment* if the submitted claim was paid less than the appropriate amount.
  - Mark *Overpayment adjustment (deduct from future payments)* if paid for a particular service incorrectly and the payment must now be reduced or eliminated. The overpayments are deducted or withheld from future payments. Two examples of overpayment adjustments are:
    - A provider that billed and was paid for two units of service, but later discovered that only one unit was rendered
    - A provider that billed and was paid for a service, but later received a late payment from another insurance carrier
  - Mark *Refund adjustment (check attached)* and enter the check number in the space provided if it is necessary to refund money. The *check number,* usually found in the upper-right corner of the check, is the series number of the provider's personal, business, or cashier's check, money order, or returned IHCP check. Refund checks should be made payable to **Indiana Medicaid** or **IHCP**. Providers must always indicate the check number on the refund adjustment.

The following procedures expedite the paid claim adjustment process:

- Use the appropriate adjustment request form and complete all items requested on the form, including the following:
  - Provide a detailed description of the reason for the adjustment request.
  - Include a contact person's name and telephone number.
- Attach a copy of the originally submitted claim form.
- Attach a copy of the RA that indicates how the claim was previously paid.
- Include a copy of documentation to support the need for an adjustment, such as an EOMB.

Submit non-check-related adjustment requests and underpayment adjustment requests to the following address:

DXC Adjustment Forms
P.O. Box 7265
Indianapolis, IN 46207-7265

Submit adjustments that include a refund to:

DXC Refunds
P.O. Box 2303, Department 130
Indianapolis, IN 46206-2303

Submit adjustments that include the return of an uncashed IHCP check to:

DXC Finance Unit
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204-4288

Circumstances Requiring the Return of an Adjustment Request

If necessary, an adjustment analyst sends a letter to the provider stating why an adjustment cannot be performed and what additional information is required. The letter is initiated by the adjustment analyst, merged with the original adjustment request, and returned to the provider. The following list contains reasons for returning an adjustment request:

- An adjustment request is received to adjust a denied claim or to adjust a claim that has been appropriately paid according to policy guidelines.
- A check received by the Adjustment Unit does not belong to the IHCP or any of the State programs administered by DXC.
- An adjustment request was received that is past the 60-day filing limit, and the accompanying documentation does not support extending the filing limit.
- An adjustment request has invalid or missing information about the data to be adjusted.

Claim Adjustment Processing and Tracking

Providers should retain a copy of the adjustment request form for tracking and possible future filing limit documentation until the adjustment is adjudicated. For adjustments submitted electronically, providers should document the new ICN/Claim ID provided after they complete the transaction.

Adjustments do not appear on the RA until the adjustment is completed. If an adjustment is not reflected on an RA or 835 transaction after 45 days, the provider should contact the Customer Assistance Unit toll-free at 1-800-457-4584.