INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Claim Adjustments

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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	Semiannual update: • Changed Indiana*AIM* references to *Core*MMIS • Changed internal control number (ICN) references to Claim ID • Removed references to *Care Select* • Updated the Customer Assistance telephone number • Updated the *Adjustments for Certain Line-Item Denials* section • Updated the *Retroactive Rate Adjustments for Long-Term Care Facilities* section • Updated the region code in the *Mass Adjustments* section • Updated the *Adjustment Submission Procedures* section, including: – Consolidated subsections about filing adjustments by mail – Removed information about ordering adjustment forms by mail – Replaced references to Medicare Remittance Notice (MRN) with Explanation of Medicare Benefits (EOMB) – Added note box about including TPL and Medicare information at the detail level for applicable claim types – Updated addressee on mailing addresses for submitting adjustments – Updated information in the *Electronic Voids and Replacements* subsection	FSSA and HPE

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Introduction

Claim adjustments are changes to claim reimbursements that Indiana Health Coverage Programs (IHCP) has made to providers. This document provides information about four 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.*
>
> *Hewlett Packard Enterprise 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

Regardless of the type, an adjustment is performed to change the amount paid on a previously paid claim. This section outlines four types of claim adjustments:

- Check-related adjustments
- Non-check-related adjustments
- Retroactive rate adjustments for long-term care facilities
- Mass adjustments

Check-Related Adjustments

A provider can initiate a check-related adjustment 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 a Remittance Advice (RA) statement or the 835 transaction with a region code of 51, which means the first two digits of the Claim ID are 51.

Non-Check-Related Adjustments

A non-check-related adjustment is an adjustment 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.

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.

Detailed information about accounts receivable can be found in the *Financial Transactions and Remittance Advice* module. A non-check-related adjustment is identified on the RA statement or 835 transaction with a region code of 50, which means the first two digits of the Claim ID are 50.

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.

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 Family and Social Services Administration (FSSA) and Hewlett Packard Enterprise. 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 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.

Mass Adjustments

The FSSA, HMS, Myers and Stauffer, or Hewlett Packard Enterprise can initiate a *mass adjustment*. 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 with a region code of 52, which means the first two digits of the Claim ID are 52.

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 nonpharmacy paid claim adjustment requests, electronically or by mail. Information about submitting adjustment requests for paid pharmacy claims using the *Pharmacy Paid Claim Adjustment Request Form* can be found in the *Pharmacy Services* module.

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.

Submitting Adjustment Requests 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.

> *Note: Many claim types require TPL and Medicare information to be submitted at the detail level. If the claim type of the adjustment request requires this detail-level information to be submitted, the provider must submit the information at the detail level on the adjustment request form, 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. See the Claim Submission and Processing module for details.*

- The 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 Claim ID must be used.
- Submit only one 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:

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

Submit adjustments that include a refund to:

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

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

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

Electronic Voids and Replacements

When submitting adjustments electronically, the transaction is called a void or replacement, which is the *Health Insurance Portability and Accountability Act* (HIPAA) name for adjustments:

- A *void* results in the full recoupment of the originally paid claim, and a new Claim ID beginning with a region code of 63 is generated.
- When a claim is *replaced*, it is reprocessed with the appropriate modifications, and a new Claim ID beginning with a region code of a 61or 62 is generated.

A void or replacement may be performed using the 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.

Circumstances Requiring a 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 Hewlett Packard Enterprise.
- 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. 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.