



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Claim Adjustments

Voids and Replacements

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Version	Date	Reason for Revisions	Completed By
		- Updated the Submitting Adjustments by Mail section - Updated the Voluntary Self-Disclosure of Provider Overpayments section	

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Claim Adjustments: Voids and Replacements

*Note: This module pertains to adjustments to claims processed by Gainwell Technologies, which includes all **fee-for-service (FFS)** claims for the Indiana Health Coverage Programs (IHCP) **except** FFS pharmacy claims (which are handled by [Optum Rx](#)) and brokered nonemergency transportation claims (which are handled by [Verida](#)).*

Managed care claims – including for Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging (PathWays) members – are handled by the managed care entity (MCE) with which the member is enrolled. Each MCE establishes and communicates its own criteria for claim adjustments.

Contact information for Optum Rx, Verida and each MCE is included in the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers.

For updates to the information in this module, see [IHCP Bulletins](#) at in.gov/medicaid/providers.

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 by the IHCP of the originally paid claim.
- A *replacement* is when a paid claim is reprocessed by the IHCP with the appropriate modifications.

Note: For replacements, it is important that providers adhere to all filing limit guidelines. See the [Filing Limit Considerations for Claim Adjustments](#) section for more information.

This document explains the various types of paid-claim adjustments and provides information about submitting adjustment requests for paid fee-for-service (FFS), nonpharmacy claims.

Types of Adjustments

All claim adjustments (voids and replacements) are performed to make changes to a previously paid claim. Only the most recent paid claim can be voided or adjusted. This section outlines three 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)

When an adjusted claim appears on the remittance advice (RA) statement or the 835 electronic 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.

Note: If the IHCP overpays a provider, the provider is obligated to return the excess payment using one of the adjustment methods described in the following sections

Check-Related Adjustments

When an excess payment has been made by the IHCP, the provider can initiate a check-related adjustment (void or replacement) and send 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 (a refund adjustment) or the entire payment on a claim (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 – Replacement claims, check related (for paper or automatic audit agency, partial refund and/or full recoupments)
- 54 – Stale dated check voids
- 57 – Replacements – void check related (paper or audit full recoupments)

Non-Check-Related Adjustments

When the IHCP makes an incorrect or partial payment (underpaid or overpaid) on a claim, the provider can initiate a non-check-related adjustment (void or replacement). This adjustment 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 due to a full claim overpayment, the provider voids the claim and the IHCP sets up an accounts receivable 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 – Paper single replacement claim, noncheck or automatic audit agency noncheck (for partial replacement and/or full recoupment)
- 56 – Mass void request or single claim void (paper or audit full recoupments)
- 61 – Provider replacement – Electronic with an attachment or claim note

- 62 – Provider replacement – Electronic without an attachment or claim note
- 63 – Provider-initiated electronic void

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 Claims Resolutions and Adjustments 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 Claims Resolutions and Adjustments Unit. Claims billed with multiple dates of service on one detail line, or *span dated*, must be resolved by the Claims Resolutions and Adjustments Unit.

Mass Adjustments

The Family and Social Services Administration (FSSA), Myers and Stauffer, or Gainwell 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 may include adjustments for a retroactive rate for long-term care facilities or end-of-month adjustments for waiver liability.

Mass adjustments can apply to many providers or one provider and can be either of the following:

- *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 claim payments.

Mass adjustments can be used when a system problem or a retroactive policy or rate change caused a group of claims to be paid or denied in error, or to be reimbursed at an incorrect rate. 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 replacements, non-check-related
- 55 – Mass replacement, institutional provider retroactive rate
- 56 – Mass void request or single claim void (paper or audit full recoupments)
- 64 – Waiver liability (formerly referred to as spend-down) end of month (EOM) auto-initiated mass replacement
- 80 – Reprocessed denied claims

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 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 Gainwell. The rates on the IHCP Core Medicaid Management Information System (*CoreMMIS*) provider file are updated automatically, and retroactive rate claim adjustments are systematically initiated.

CoreMMIS 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 in.gov/medicaid/providers for contact information.

End-of-Month Adjustments for Waiver Liability

At the end of each month, *CoreMMIS* automatically initiates a mass replacement of claims for liability related to Home and Community-Based Services (HCBS) 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.

Filing Limit Considerations for Claim Adjustments

Claim adjustments may be initiated **only if payment has been made** on a claim (including partial payments or payments of zero), and the provider believes the payment to be incorrect due to erroneous or incomplete information submitted on the claim. The Claims Resolutions and Adjustments Unit must receive the corrected replacement claim **within 60 days of notification of the original claim's disposition**. The date of notification is considered to be the date on the RA for the claim payment.

*Note: If erroneous claim information causes a claim to be **denied**, rather than to pay incorrectly, the provider may resubmit the claim with corrections. However, a claim that is corrected and resubmitted after a denial is considered to be an **initial claim**, not an adjusted claim, and, as such, is subject to the same filing limit as the original claim. The IHCP filing limit for FFS claims is 180 days from the date of service (or, for inpatient claims, from the date of discharge). For more information about claim-filing limits, including exceptions and extensions, see the [Claim Submission and Processing](#) module.*

The following rules also apply to filing limits related to claim adjustments:

- Requests for an extension of the adjustment filing limit will be considered on a case-by-case basis. Adequate documentation of the extenuating circumstance (such as a retroactive policy change) must be included with the adjustment request.
- Overpayment adjustment requests are not subject to timely filing limits. Any overpayment identified by a provider must be returned to the IHCP regardless of the filing limit, as indicated in the [Provider and Member Utilization Review](#) module. See the [Adjustment Submission Procedures](#) section for special instructions if the overpayment adjustment is filed beyond the standard filing limit.

- Crossover claims are not subject to IHCP filing limits. No timely filing documentation is required when submitting a crossover claim or claim adjustment to the IHCP, as long as the Medicare or Medicare Replacement Plan information is entered correctly on the claim. Note that a claim is considered a crossover claim only if Medicare or a Medicare Advantage Plan *paid* for the service (including payments of \$0, due to copayment or coinsurance). Services *denied* by Medicare or a Medicare Advantage Plan are *not* considered crossover claims and are not exempt from the filing limit.
- If an adjustment to a paid claim is requested **after the timely filing limit for the initial claim has passed** (that is, more than 180 days after the date of service, for FFS claims), the replacement claim must include timely filing documentation for the initial claim. For example, if the initial claim was filed within 180 days of the date of service, the paid Medicaid EOB for the initial claim should be attached to the replacement claim to document that the initial claim was filed timely. If timely filing was waived or extended for the initial claim, the replacement claim must include the same claim note or attachment that was submitted with the original claim, documenting the reason for waiving or extending the filing limit. See the [Adjustment Submission Procedures](#) section for details.
- If a provider is adding a new service detail to a claim that is being adjusted, the initial claim submission filing limit applies – meaning the replacement claim must be submitted within 180 days from the date of service, unless documentation is included that supports waiving timely filing.

Providers may **void** a claim (either electronically or by mail) without regard to the filing limits.

Adjustment Submission Procedures

Adjustment requests for paid, FFS nonpharmacy claims may be submitted electronically or by mail as described in the following sections. As indicated in the [Filing Limit Considerations for Claim Adjustments](#) section, adjustment requests should be submitted within 60 days of notification of the claim's disposition. This limit does not apply to overpayment adjustments or adjustments to crossover claims.

When submitting an adjusted claim after the timely filing limit for the *initial* claim has passed, the following special procedures must be followed to avoid inadvertent recoupment of the entire claim paid amount:

- **Underpayment** adjustments submitted after the filing limit for the initial claim has passed must include documentation that the initial claim was filed timely (such as a copy of the paid-claim EOB) or, if the filing limit was extended or waived for the initial claim, then the replacement claim must include the same claim note or attachment that was submitted with the original claim, allowing it to bypass the standard filing limit (as described in the [Claim Submission and Processing](#) module).
- **Overpayment** adjustments submitted after the filing limit for the initial claim has passed must include a claim note or attachment indicating: “**Adjustment due to overpayment. Timely filing does not apply.**” For overpayment adjustments submitted by mail, an adjustment request form, marked to indicate *Overpayment adjustment (deduct from future payments)* or *Refund adjustment (check attached)*, can be used in lieu of such an attachment, as described in the [Submitting Adjustments by Mail](#) section.

For self-identified overpayments that meet certain self-disclosure requirements, follow the instructions in the [Voluntary Self-Disclosure of Provider Overpayments](#) section. For information regarding overpayment adjustments resulting from an Office of Medicaid Policy and Planning (OMPP) audit, see the [Provider and Member Utilization Review](#) module.

Adjustment requests are considered only for previously paid claims or line items (including those that paid at zero dollars). Refunds to paid claims are considered adjustments; therefore, refunds must comply with these adjustment procedures.

*Note: Many claim types require third-party liability (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. See the [Claim Submission and Processing](#) and [Third-Party Liability](#) modules for more information.*

Submitting Adjustments Electronically

An electronic void or replacement of an FFS claim may be performed using the [IHCP Provider Healthcare Portal](#) (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers, or submitted via the appropriate 837 claim transaction.

Instructions for Void and Replacement Through the IHCP Portal

To perform a void or replacement on a paid claim in the IHCP Portal, first open the most recent paid claim (see the [Claim Submission and Processing](#) module for instructions on searching claims) and then do one of the following:

- Click **Edit** to perform a replacement – see the [Edits \(Replacements\)](#) section.
- Click **Void** to void the claim – see the [Voids](#) section.

Figure 1 – Options to Edit (Replace) or Void a Claim

Total Charged Amount \$100.00	
Does the provider have a signature on file?	Yes
Does the provider accept assignment for claim processing?	Yes
Are benefits assigned to the provider by the patient or their authorized representative?	Yes
Does the provider have a signed statement from the patient releasing their medical information?	Yes
Expand All Collapse All	
Diagnosis Codes +	
Other Insurance Details +	
Service Details +	
Claim EOB Information +	
Claim Adjustment Reason Code Information +	
No Attachments exist for this claim	
No Claim Notes exist for this claim	
No Adjudication Errors exist for this claim	
Edit	Copy Void Print Preview

Edits (Replacements)

Providers can edit and resubmit (replace) paid claims on the IHCP Portal.

Reminder: For claims that are subject to timely filing limits, if the initial claim filing limit (180 days from the date of service) has passed when the edited replacement claim is submitted, the replacement claim must include timely filing documentation – such as a copy of the paid-claim EOB showing that the initial claim was filed timely, or (if timely filing was waived for the initial claim), the same claim note or attachment that was submitted with the initial claim, allowing it to bypass the filing limit..

Crossover claims and overpayment adjustments are not subject to timely filing limits:

- *Overpayment adjustments submitted online after the timely filing limit for the initial claim has passed must include the following claim note: “Adjustment due to overpayment. Timely filing does not apply.”*
- *No timely filing documentation is required for crossover claim adjustments if Medicare payer information is completed correctly on the claim.*

After clicking **Edit** for a selected claim (see Figure 1), the user can navigate through the claim and modify fields as needed:

- Click **Continue** to move to the next section of the claim.
- Click the appropriate **Back to Step** button to return to a previous section of the claim.

For example, to change information within a service detail (line item), the user navigates to the *Service Details* panel, clicks the hyperlinked number for the applicable detail row, makes the necessary changes and resubmits the claim.

New service details may also be added to the replacement claim, as follows:

Note: New service details added to a paid claim are subject to the initial claim filing limit of 180 days from date of service, not the adjustment filing limit of 60 days from the RA date.

1. Open the paid claim and click **Edit**.
2. Locate the *Service Details* panel and click the **[+] Click to add service detail** link.

Figure 2 – Adding a Service Detail to a Submitted Claim

Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/19/2016	09/19/2016	11-Office	92014-EYE EXAM&TX ESTAB PT 1/>VST	\$110.00	1.00 Unit	Remove
2	09/19/2016	09/19/2016	11-Office	92015-DETERMINE REFRACTIVE STATE	\$35.00	1.00 Unit	Remove
Add Click to add service detail.							
Attachments							
Click the Remove link to remove the entire row.							
#	Transmission Method	File	Control #	Attachment Type	Action		
Add Click to add attachment.							
Claim Note Information							
Click the Remove link to remove the entire row.							
#	Note Reference Code	Note Text					Action
Collapse Click to collapse.							
Note Reference Code							
Note Text							
Add Cancel							
No Adjudication Errors exist for this claim							
Back to Step 1 Back to Step 2				Resubmit Cancel			

3. Add the information for the new service detail and then click **Add** to add the new service detail to the *Service Details* panel of the claim.

Figure 3 – Service Detail Information Fields

Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/19/2016	09/19/2016	11-Office	92004-EYE EXAM NEW PATIENT	\$110.00	1.00 Unit	Remove
2	09/19/2016	09/19/2016	11-Office	92015-DETERMINE REFRACTIVE STATE	\$35.00	1.00 Unit	Remove
Collapse Click to collapse.							
*From Date 09/26/2016 To Date 09/26/2016 *Place of Service 11-Office							
*Procedure Code 99213-OFFICE/OUTPATIENT VISIT EST *Diagnosis Pointers 1							
Modifiers							
Charge Amount \$100.00 *Units 1.00 *Unit Type Unit EPSDT ☐ Family Plan ☐ EMG ☐							
Rendering Provider ID ID Type Rendering Taxonomy							
Line Item Control#							
NDC for Service Detail Add Note for Service Detail Add							
Add Cancel							

4. After all fields are modified as needed, click **Resubmit** to initiate the submission process.

Figure 4 – Claim Replacement Ready to Resubmit

Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/19/2016	09/19/2016	11-Office	92004-EYE EXAM NEW PATIENT	\$110.00	1.00 Unit	Remove
2	09/19/2016	09/19/2016	11-Office	92015-DETERMINE REFRACTIVE STATE	\$35.00	1.00 Unit	Remove
3	09/26/2016	09/26/2016	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$100.00	1.00 Unit	Remove
Add Click to add service detail.							
Attachments							
Click the Remove link to remove the entire row.							
#	Transmission Method	File	Control #	Attachment Type	Action		
Add Click to add attachment.							
Claim Note Information							
Click the Remove link to remove the entire row.							
#	Note Reference Code	Note Text					Action
Collapse Click to collapse.							
Note Reference Code							
Note Text							
Add Cancel							
No Adjudication Errors exist for this claim							
Back to Step 1 Back to Step 2				Resubmit Cancel			

5. Verify the data is correct and then click **Confirm** to submit the claim adjustment.

Figure 5 – Claim Submission Confirmation Page

Confirm Professional Claim - 00000000000000000000						
Select Print Preview before you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.						
Provider Information						
Billing Provider ID	XXXXXXXXXX	ID Type	NPI	Name	XXXXXXXXXX	
Rendering Provider ID	XXXXXXXXXX	ID Type	NPI	Name	XXXXXXXXXX	
Rendering Taxonomy	XXXXXXXXXX					
Referring Provider ID	XXXXXXXXXX	ID Type	NPI	Name	XXXXXXXXXX	
Service Facility Location ID	_	ID Type	_	Name	_	
Patient Information						
Member ID	XXXXXXXXXX	Gender	Female			
Member	XXXXXXXXXX					
Birth Date	XXXXXXXXXX					
Claim Information						
Claim Status	Finalized Payment	Claim Status Date	09/23/2016			
Hospital From Date	_	Hospital To Date	_			
Date Type	_	Date of Current	_			
Accident Related	_	Authorization Number	_			
Patient Number	XXXXXXXXXX	Special Program	_			
Medical Record Number	_	Total Charged Amount	\$245.00			
Does the provider have a signature on file? Yes						
Does the provider accept assignment for claim processing? No						
Are benefits assigned to the provider by the patient or their authorized representative? No						
Does the provider have a signed statement from the patient releasing their medical information? No						
Expand All Collapse All						
Diagnosis Codes						
Service Details						
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units
1	09/19/2016	09/19/2016	11-Office	92004-EYE EXAM NEW PATIENT	\$110.00	1.00 Unit
2	09/19/2016	09/19/2016	11-Office	92015-DETERMINE REFRACTIVE STATE	\$35.00	1.00 Unit
3	09/26/2016	09/26/2016	11-Office	99213-OFFICE/OUTPATIENT VISIT EST	\$100.00	1.00 Unit
Claim EOB Information						
No Other Insurance Details exist for this claim						
No Attachments exist for this claim						
No Claim Notes exist for this claim						
No Adjustment Reason Codes exist for this claim						
No Adjudication Errors exist for this claim						
Back to Step 1 Back to Step 2 Back to Step 3 Print Preview Confirm Cancel						

6. A confirmation message appears, showing the Claim ID for the replacement. Providers should keep this number in their reference records.

Figure 6 – Claim ID and Status

Voids

A void can only be completed on a paid claim. Providers can complete a void to have the entire payment amount returned.

After clicking **Void** for the selected claim (see [Figure 1](#)), follow these steps to void the claim:

1. When the IHCP Portal asks for confirmation that you want to void the claim, click **OK** to confirm.

Figure 7 – Void Confirmation Question

2. When the final confirmation message appears to confirm that the request has been processed, click **OK** again.

Figure 8 – Void Confirmation Notice

3. The IHCP Portal lists the voided claim in the *Search Results* panel as a new record in with *Finalized Denied* as the claim status.

Figure 9 – Voided Claim in Search Results

Search Results									
To see service line information or to view a remittance advice, click on the '+' next to the claims ID.									
Total Records: 3									
+/-	Claim ID	Claim Type	Claim Status	Service Date ▼	Member ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Member Responsibility
+	1111111111111111	Professional	Finalized Payment	10/05/2016 10/06/2016			\$103.98	—	
+	1111111111111111	Professional	Finalized Denied	10/05/2016 10/06/2016			\$0.00	—	
+	1111111111111111	Professional	Finalized Payment	10/05/2016			\$51.99	—	

Submitting Adjustments by Mail

Paid claim adjustments can be submitted by mail using the following forms, available from the [Forms](#) webpage at in.gov/medicaid/providers:

- *IHCP Professional, Dental, or Medicare Part B Crossover Claim Adjustment Request*
- *IHCP Institutional and Inpatient/Outpatient Crossover Claim 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 Claims Resolutions and Adjustments Unit returns the adjustment request with an explanation of why the adjustment was not processed. A completed adjustment form must be submitted before an adjustment to a paid claim can occur.

The following instructions apply to fields that appear on both claim adjustment forms:

- In the *Reason for adjustment* field, check the appropriate box for one of the following:
 - *Change third-party liability (TPL) amount* – The submitted TPL information was incorrect.
 - *Change patient deductible amount* – The submitted patient-deductible amount was incorrect.
 - *Offset or refund of entire claim amount (check Type of Adjustment field)* – The entire claim is to be refunded through the offset.
 - *Change information as indicated in fields 13-17* if any of the detail information should be corrected.
 - *Medicare adjustment* – A change is required to a crossover claim. Attach all Explanations of Medicare Benefits (EOMBs) that apply to the adjustment.
- In the *Claim ID (ICN)* field:
 - Enter ICN/Claim ID of the claim to be adjusted:
 - 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.
- In the *Type of adjustment* field, check the appropriate box for one of the following:
 - *Underpayment adjustment* – The submitted claim was paid at less than the appropriate amount.
 - *Overpayment adjustment (deduct from future payments)* – The provider was paid for a particular service incorrectly and the payment must now be reduced or eliminated by deducting or withholding 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
 - *Refund adjustment (check attached)* – The provider was paid for a particular service incorrectly and is submitting a check to refund the money. The check number must be entered in the space provided. 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.

Note: Both "overpayment adjustments" (where the amount that was overpaid is deducted from future payments to the provider) and "refund adjustments" (where the provider returns the amount that was overpaid via check) are adjustments due to overpayment and are therefore not subject to timely filing limits.

To expedite the paid claim adjustment process, use the appropriate adjustment request form and complete **all** items requested on the form, including providing a contact person's name and telephone number, and giving a detailed explanation of the reason for the adjustment request. Be sure to include all appropriate attachments, such as:

- A copy of the originally submitted claim form (recommended for all claim types)
- A copy of the IHCP RA that indicates how the claim was previously paid (recommended for all claim types; required for crossover claims)
- A copy of documentation to support the need for an adjustment, such as an EOMB (recommended for all claim types; required for crossover claims)
- A completed [*IHCP Third-Party Liability \(TPL\)/Medicare Special Attachment Form*](#) (required for all adjustments to details on dental, home health, outpatient or professional claims, including crossover claims)
 - This form and the [*IHCP Third-Party Liability \(TPL\)/Medicare Special Attachment Form Instructions*](#) are available at in.gov/medicaid/providers.

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

Gainwell – Adjustments
PO Box 50444
Indianapolis, IN 46250-0420

Submit adjustments that include a refund to:

Gainwell – Refunds
PO Box 2303, Dept. 130
Indianapolis, IN 46206-2303

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

Gainwell – Finance
PO Box 50458
Indianapolis, IN 46250-0418

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 Claims Resolutions and Adjustments Unit does not belong to the IHCP or any of the state programs administered by Gainwell.
- 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 Customer Assistance toll-free at 800-457-4584.

Voluntary Self-Disclosure of Provider Overpayments

Under federal law, a provider that identifies an overpayment must report the overpayment and return the entire amount to the Medicaid program within 60 days of identifying the overpayment.

The IHCP has established a self-disclosure protocol for providers to use to report Medicaid and Children's Health Insurance Program (CHIP) fee-for-service overpayments they have identified that are not considered routine adjustments.

The IHCP requests that providers use this self-disclosure protocol to report self-identified items including but not limited to the following:

- Provider billing system errors or issues that result in overpayments
- Potential violations of federal, state or local laws
- Potential violations of regulations
- Potential violations of billing, coding or other healthcare policies
- Overpayments involving specific compliance issues
- Overpayments involving cumulative amounts greater than \$1,000
- Overpayments involving fraud or violations of law

Simple, more routine occurrences of overpayments that do not meet the preceding criteria should be addressed through typical methods of resolution, such as voiding or adjusting the claim as described in the [Adjustment Submission Procedures](#) section – unless the provider feels compelled to self-report the overpayments using the self-disclosure process.

For overpayments that do meet any of the preceding criteria, providers must complete and submit the [Voluntary Self-Disclosure of Provider Overpayments Form](#). Providers should not submit payment with the self-disclosure form. The IHCP must first review the provider's completed form and validate the claim and overpayment amount. For more information, see the [Provider and Member Utilization Review](#) module and the [Protocol for Voluntary Self-Disclosure of Provider Overpayments](#) webpage at in.gov/medicaid/providers.