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 Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of Aug. 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: Feb. 13, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of Sept. 1, 2017 Published: Dec. 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of March 1, 2018 Published: May 3, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of March 1, 2019 Published: May 14, 2019	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of April 1, 2020 Published: July 30, 2020	Scheduled update	FSSA and DXC
6.0	Policies and procedures as of June 1, 2021 Published: Nov. 19, 2021	Scheduled update: • Edited text as needed for clarity • Changed DXC references to Gainwell • Added a note about filing limits in the *Introduction* section • In the *Types of Adjustments* section, added that only the most recent paid claim can be voided or adjusted • Updated the *Check-Related Adjustments* section • Updated the *Non-Check-Related Adjustments* section • Updated the *Mass Adjustments* section • Added Medicare Advantage Plan to two bullets in the *Adjustment Filing Limits* section • In the *Adjustment Submission Procedures* section, added that a claim adjustment form can be used to indicate overpayment or	FSSA and Gainwell

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		refund when submitting such adjustments by mail • Updated that providers open the most recent paid claim in the *Instructions for Void and Replacement through the Portal* section	

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Claim Adjustments: Voids and Replacements

> *Note: Gainwell Technologies handles all Indiana Health Coverage Programs (IHCP) **fee-for-service (FFS)** claims, except for pharmacy claims, which are handled by OptumRx. See the Pharmacy Services module for information regarding pharmacy claim adjustments.*
>
> *For members enrolled in a **managed care** benefit plan – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise – claim adjustments (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. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers. For information about carved-out services, see the Member Eligibility and Benefit Coverage module.*
>
> *For updates to information in this module, see IHCP Banner Pages and 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 Adjustment Filing Limits section for more information.*

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.

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.

Check-Related Adjustments

When an excess payment has been made by the IHCP, a provider is obligated to return the excess payment. 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 initiates 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 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), 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 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 or single claim void (paper or audit full recoupments)
- 64 – Waiver liability (formerly referred to as spend-down) or end-stage renal disease (ESRD) liability end of month (EOM) 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 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 (*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 in.gov/medicaid/providers 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.

Adjustment Filing Limits

Claim 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 replacement 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 limits related to claim adjustments:

- Providers can obtain an extension of the filing limit for adjustments under the same circumstances as for an initial claim submission, if adequate documentation is submitted.
- When a payment is made by Medicare or a Medicare Advantage Plan, a crossover claim is not subject to the filing limit.
- Services denied by Medicare or a Medicare Advantage Plan are not considered crossover claims and are not exempt from the filing limit.
- 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 filing instructions to avoid recoupment if the claim is beyond the standard 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.

> *Note: For claim **submissions**, 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 additional information about claim-filing limits, including exceptions and extensions, see the Claim Submission and Processing module.*

Adjustment Submission Procedures

This section outlines the process for submitting adjustment requests for paid, nonpharmacy, fee-for-service claims. Adjustment requests may be submitted electronically using the IHCP Provider Healthcare Portal (accessible from the home page at in.gov/medicaid/providers) or the appropriate 837 claim transaction, or they may be submitted by mail using the appropriate claim adjustment form.

As described in the *Adjustment Filing Limits* section, the limit for filing adjustment requests is within 60 days of notification of the claim's disposition. An adjustment may be submitted after the timely filing limit for the *initial* claim (180 days from date of service or discharge) has passed, as long as the adjustment is submitted within the *adjustment* filing limit (60 days from the RA date). However, if the date of service is more than 180 days prior to the date the adjustment is submitted, providers should submit the replacement **by mail**, rather than electronically, to avoid inadvertent recoupment of the entire claim paid amount. Providers may **void** a claim (either electronically or by mail) without regard to the filing limits.

When submitting an overpayment adjustment after the claim is beyond the standard filing limit, providers must include a claim note or attachment indicating "**adjustment due to overpayment**" or "**overpayment adjustment**," so that the claim does not automatically deny. For adjustments submitted by mail, an adjustment request form, marked to indicate overpayment or refund adjustment, can be used instead. See the *Submitting Adjustments by Mail* 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. For self-identified overpayments that meet certain self-disclosure requirements, follow the instructions in the *Voluntary Self-Disclosure of Provider Overpayments* section.

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

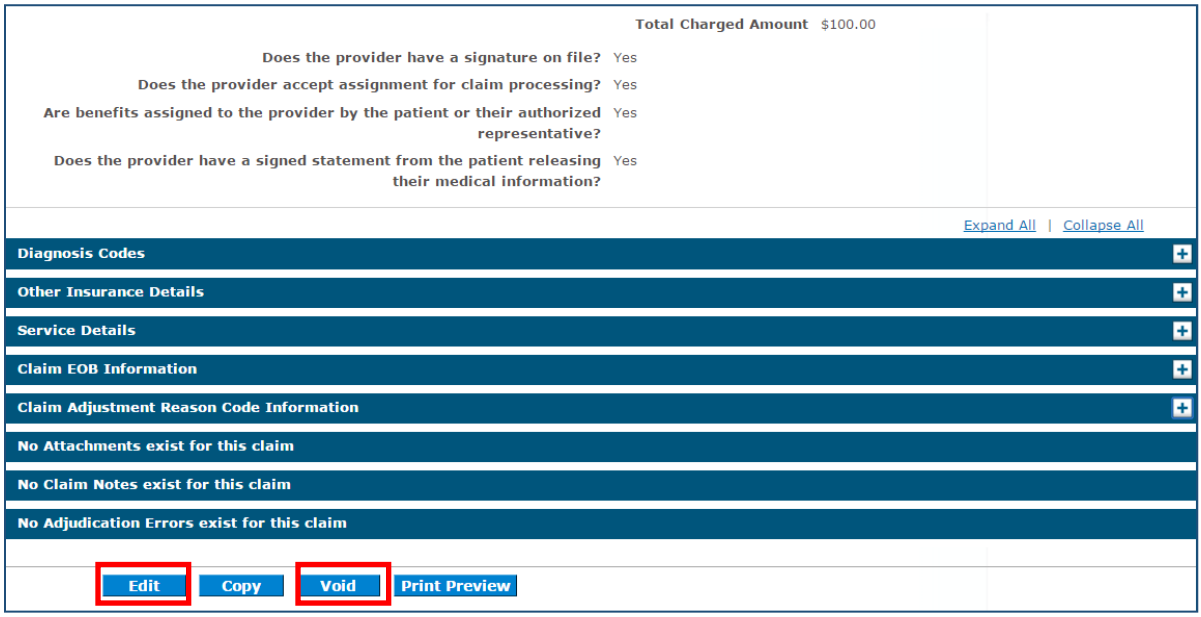
An electronic void or replacement may be performed using the IHCP Provider Healthcare Portal (Portal), accessible from the home page at in.gov/medicaid/providers, or submitted via the appropriate 837 claim transaction.

Instructions for Void and Replacement through the Portal

To perform a void or replacement on a paid claim in the 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



Edits (Replacements)

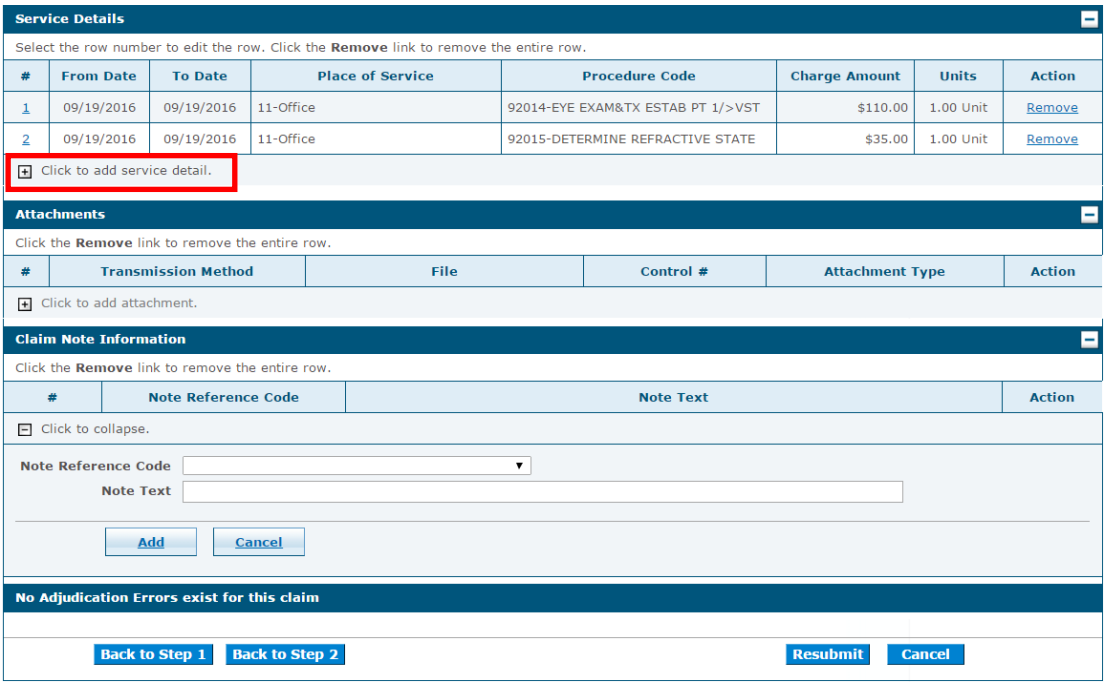
When the user clicks **Edit** for the selected claim:

1. The Portal allows the user to navigate through the claim:
   - 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.
2. Modify any field needed.

   For example, to add a service line to the claim:

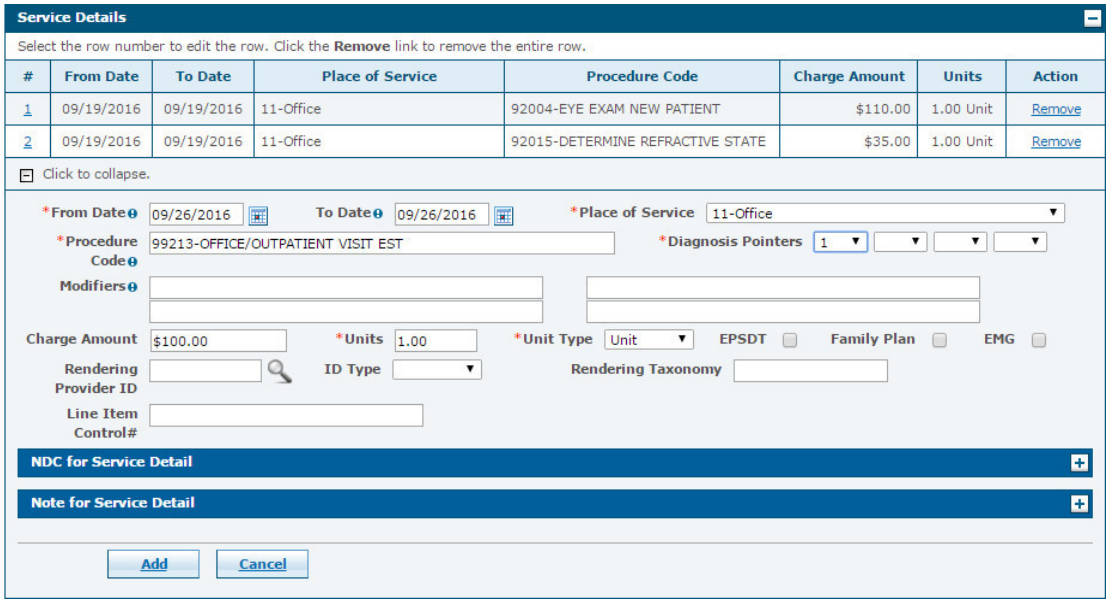
   a. Locate the *Service Details* panel of the claim and click the [**+**] **Click to add service detail** link.

Figure 2 – Adding a Service Detail to a Submitted Claim



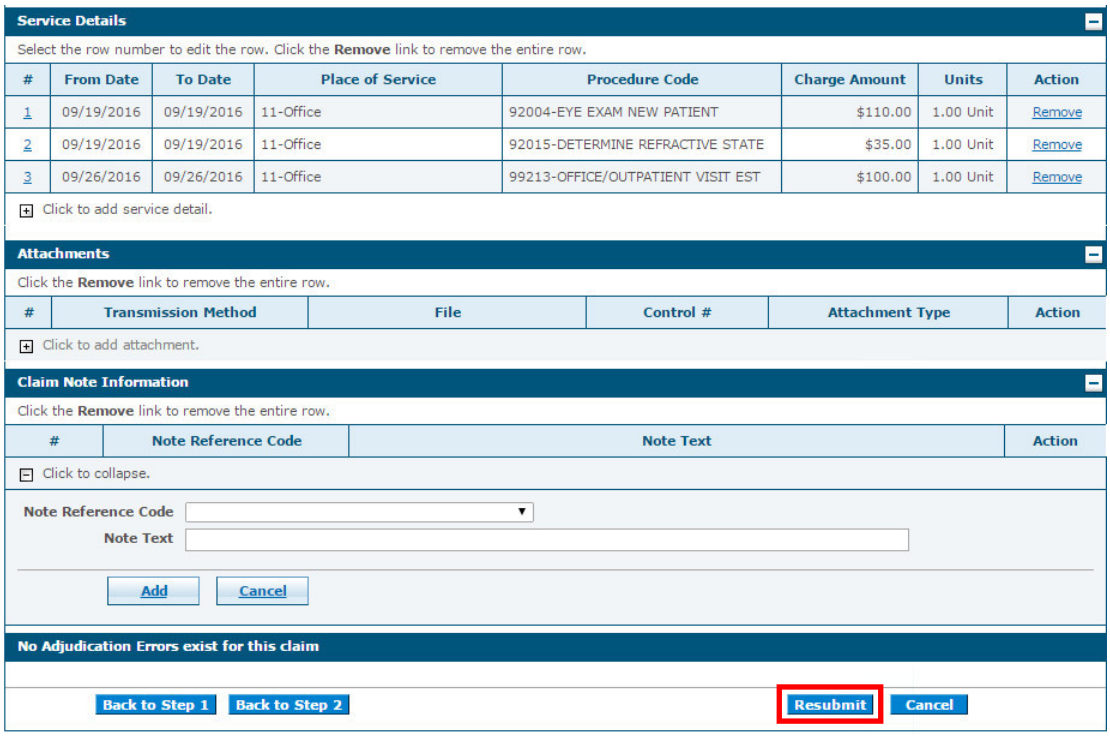
b. Add the information for the new service detail and then click **Add** to add the new service detail to the *Service Details* panel of the claim.

Figure 3 – Service Detail Information Fields



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

Figure 4 – Claim Replacement Ready to Resubmit



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

Figure 5 – Claim Submission Confirmation Page

Confirm Professional Claim - ID 4016266067408

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		ID Type	NPI	Name	
Rendering Provider ID		ID Type	NPI	Name	
Rendering Taxonomy					
Referring Provider ID		ID Type	NPI	Name	
Service Facility Location ID	_	ID Type	_	Name	_

Patient Information

Member ID		Gender	Female
Member			
Birth Date			

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	_		
Patient Number		Authorization Number	_
Medical Record Number	_	Special Program	_
		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

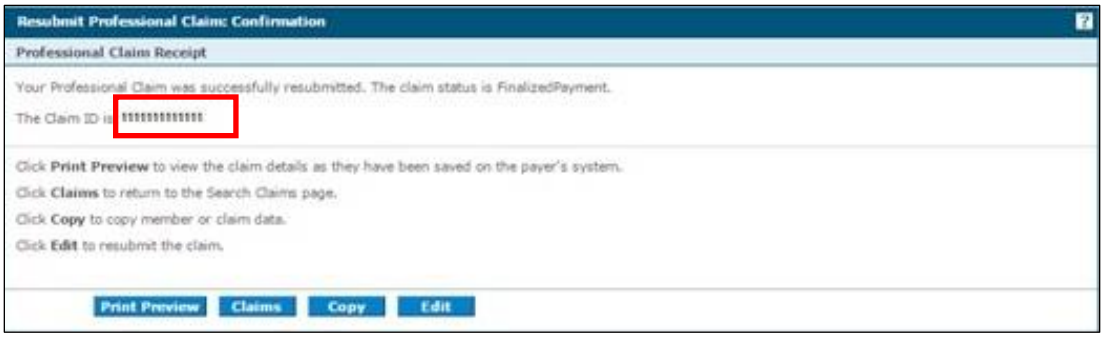
No Adjustment Reason Codes exist for this claim

No Adjudication Errors exist for this claim

Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | Confirm | Cancel

5. 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

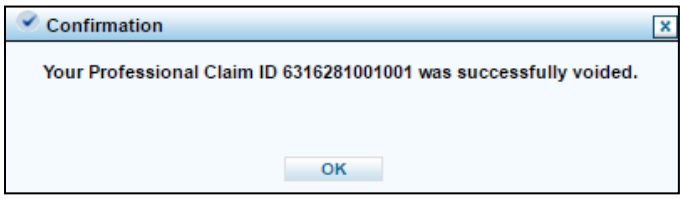
When the user clicks **Void** for the selected claim:

1. The Portal asks for confirmation that the user wants 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 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

Submitting Adjustments by Mail

Paid claim adjustments can be submitted by mail using the following forms, available from the *Forms* page at in.gov/medicaid/providers:

- *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 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:
  - Mark *Change third-party liability (TPL) amount* if the submitted 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 fields 13-17* 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.
- 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:
  - 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.

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 types; required for crossover claims)

- A copy of documentation to support the need for an adjustment, such as an EOMB (recommended for all claims 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
P.O. Box 7265
Indianapolis, IN 46207-7265

Submit adjustments that include a refund to:

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

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

Gainwell Finance Unit
950 N. Meridian St., 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 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 the Customer Assistance Unit 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 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 this self-disclosure protocol be used in the following scenarios:

- To self-report overpayments involving specific compliance issues
- To self-report overpayments involving cumulative amounts greater than $1,000
- To self-report 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 Packet*, along with the repayment (if paying by check), as directed in the packet.

For more information, see the *Provider and Member Utilization Review* module and the *Protocol for Voluntary Self-Disclosure of Provider Overpayments* page at in.gov/medicaid/providers.