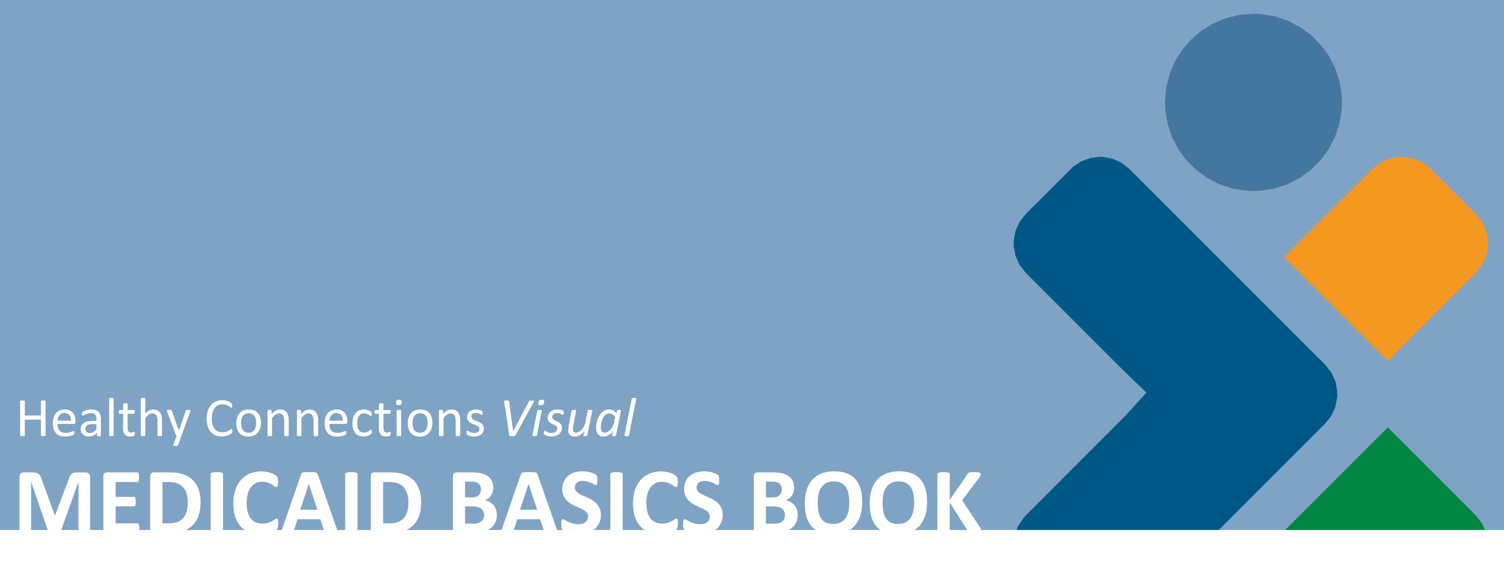

Adjustments

An illustrated companion to the interactive courses at: MedicaideLearning.com.

This topic includes content from the exclusive Overview of Adjustments course in addition to the foundational Medicaid Basics course.

Updated September 2022

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Adjustments

Adjustments can only be made to paid claims and can be made anytime any correction is needed, regardless of any change in payment to the provider.

Gross- vs. claim-level

There are two different types of adjustments, Gross-Level and Claim-Level.

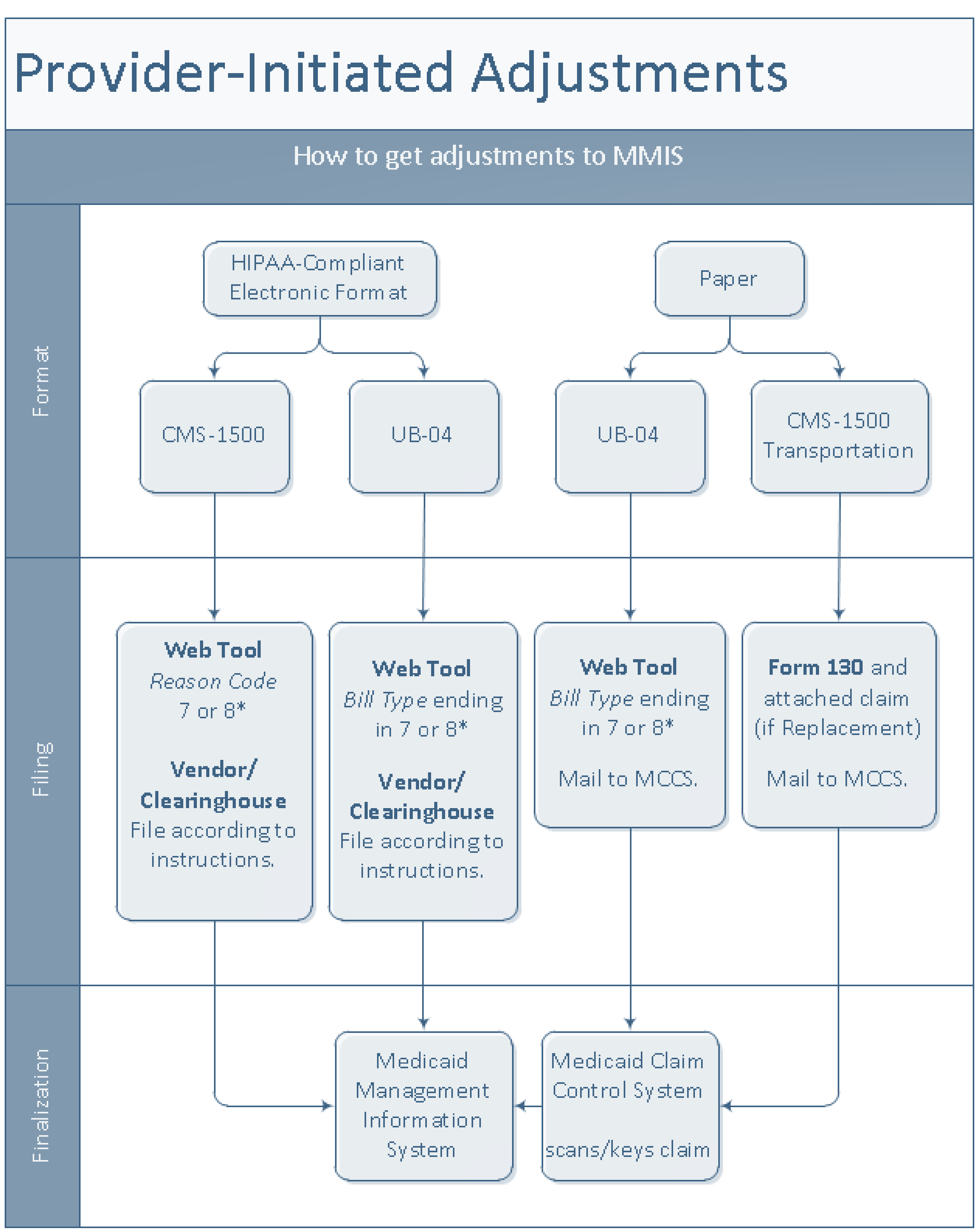
	Gross-Level Adjustment	Claim-Level Adjustment
Definition	A debit or credit initiated by South Carolina Medicaid	A Void or Void/Replacement initiated by provider or Medicaid
Scope	• Not tied to a particular claim or recipient • Can adjust multiple claims at one time	• Tied to a particular claim or recipient • Limited to one claim per adjustment request
Examples/ specifics	• cost settlements, disproportionate share • Claims no longer available in claims history • Claims pulled into recovery for Medicare or other health insurance when only a portion of the amount is being recouped	• Paid only claims • Claim-level adjustments are always 100% adjusted. • Provider ID, CCN, and Recipient ID on the form must match the original claim. • Void Only adjustments must be initiated within 15 months from the check date of the original claim. • Void/Replacement adjustments must meet all billing requirements, including timely filing. • Do not send a check to Medicaid.
Initiated by:	• Medicaid	• Provider or Medicaid
How to initiate:	• Contact the Provider Service Center. • Exception – If adjustment is related to TPL, contact MIVS.	• Submit electronically via a vendor/ clearinghouse or the Web Tool • Submit hard copy via the Form 130 – For CMS-1500 or Transportation • Note: The submission method of the adjustment does not have to be the same as the submission method of the original claim. *Exception*: A UB-04 adjustment must be submitted in same medium as original filed claim. Exception: CMS-1500 claims filed electronically with more than 8 lines must be adjusted electronically.
Visit Counts		• Visit Counts are stored in the beneficiary's claim record. • Claim-level adjustment process can affect the visit count for services with frequency limitations: ○ Ambulatory

	○ Home Health ○ Chiropractic ○ Mental Health ○ Private Rehabilitation

Void vs. Void/Replacement

	Void	Void/Replacement
What it means	• Original claim will be cancelled and not replaced. • If claim is voided and later needs to be replaced, replacement must be submitted as a new claim.	• Original claim contains an error that needs to be corrected. Adjustment can be filed even if the change does not result in a different reimbursement.
Results	• The void-only claim is going to take all the money back that we paid you for that claim and that's it.	• The void/replacement is going to take the money back, but replace it with the replacement claim.
Special situations	• If initiating an adjustment to change the provider ID or the recipient ID, **always** complete a Void Only transaction and file a new claim.	• If performing an adjustment due to third- party liability, **always** initiate a Void/Replacement. • Keep in mind that timely filing guidelines still apply when filing replacement claims.
Visit Counts	• The visit count will be restored by the same number and type of visits as the original claim once void is processed.	• The new visit count will be applied to the beneficiary record after the replacement claim is processed. • The visit count will be held or saved until the replacement claim processes. • If the status of the Replacement claim is **PAID**, the visit counts that were "held" will be used for that claim. (If the count exceeds limitations, the excess visits will be denied.) • If the status of the Replacement claim is **Rejected**, the "held" visit counts will be returned to the "beneficiary's record" within the MMIS.

Adjustment Process

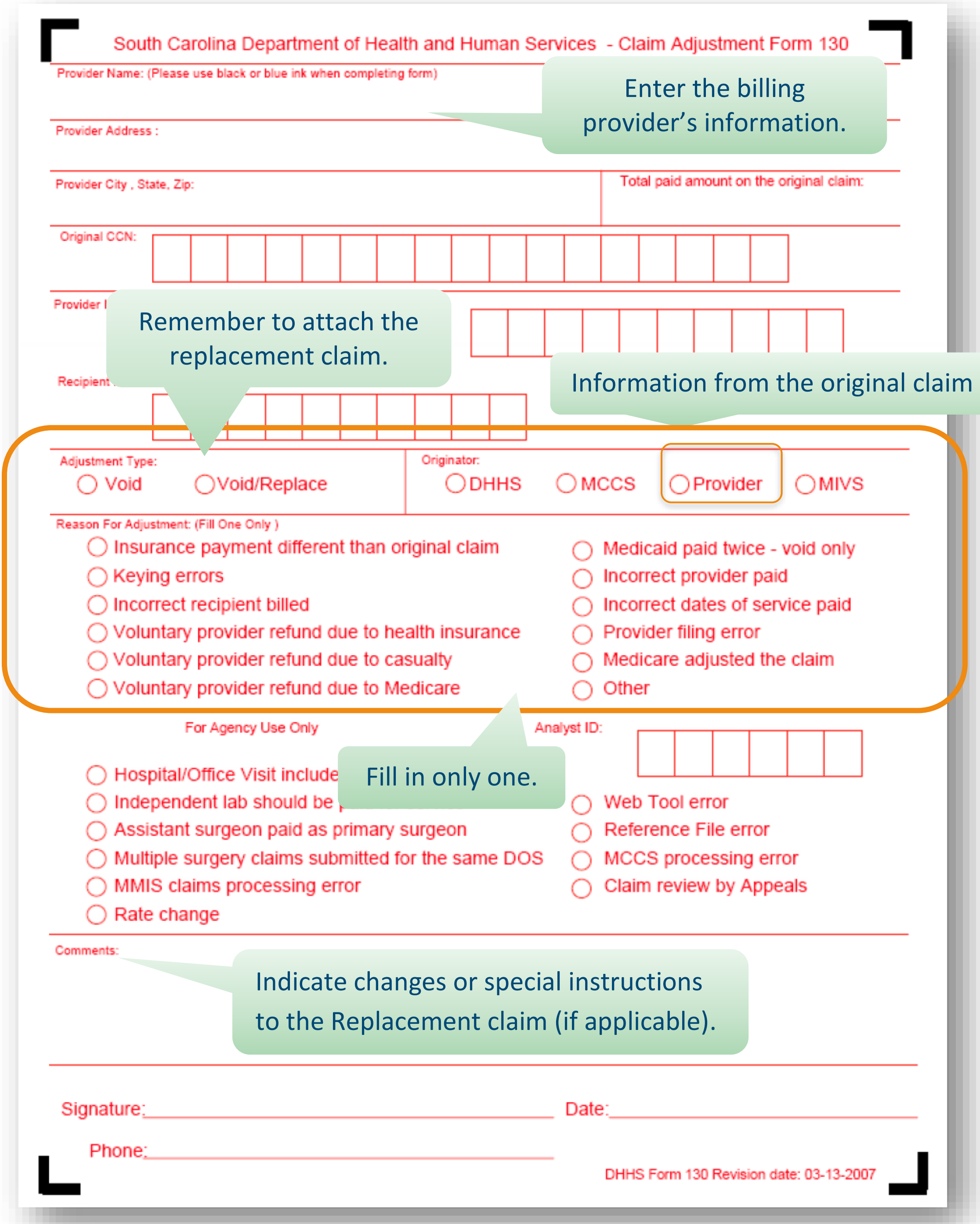


*7 = Void; 8 = Void/Replacement

Form 130

A Form 130 is used to process Void and Void/Replacements on paid-only claims. This form must reflect the same Claim Control Number (CCN), Provider ID, and Recipient ID as the original claim.

SCDHHS Form 130 – Claim-level Adjustments



South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider I

Recipient

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

◯ Insurance payment different than original claim
◯ Keying errors
◯ Incorrect recipient billed
◯ Voluntary provider refund due to health insurance
◯ Voluntary provider refund due to casualty
◯ Voluntary provider refund due to Medicare
◯ Medicaid paid twice - void only
◯ Incorrect provider paid
◯ Incorrect dates of service paid
◯ Provider filing error
◯ Medicare adjusted the claim
◯ Other

For Agency Use Only

Analyst ID:

◯ Hospital/Office Visit include
◯ Independent lab should be
◯ Assistant surgeon paid as primary surgeon
◯ Multiple surgery claims submitted for the same DOS
◯ MMIS claims processing error
◯ Rate change
◯ Web Tool error
◯ Reference File error
◯ MCCS processing error
◯ Claim review by Appeals

Comments:

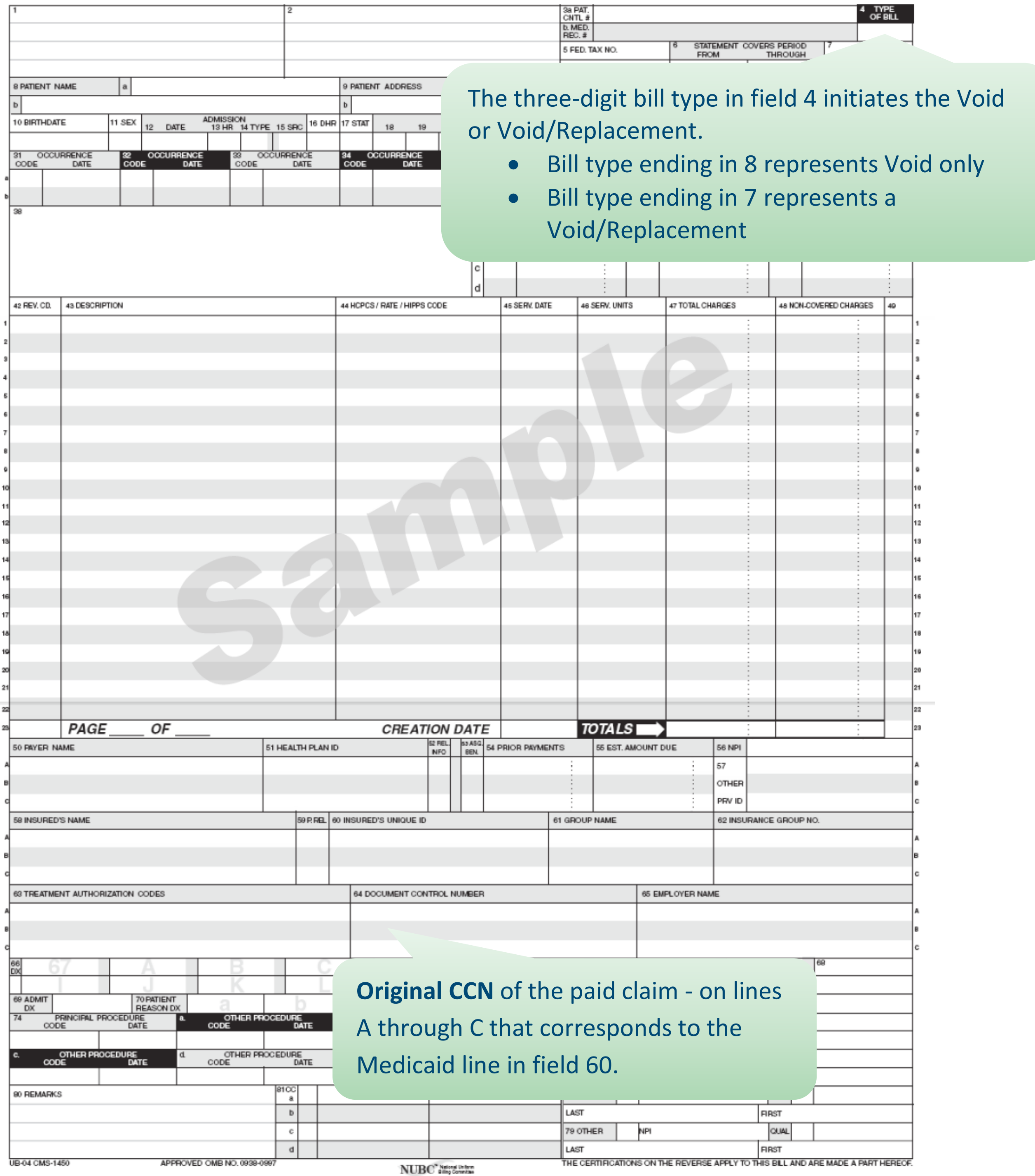
Signature:______ Date:______

Phone:______

DHHS Form 130 Revision date: 03-13-2007

UB-04 Adjustments

A UB-04 is used to process Void and Void/Replacements on institutional paper claims.

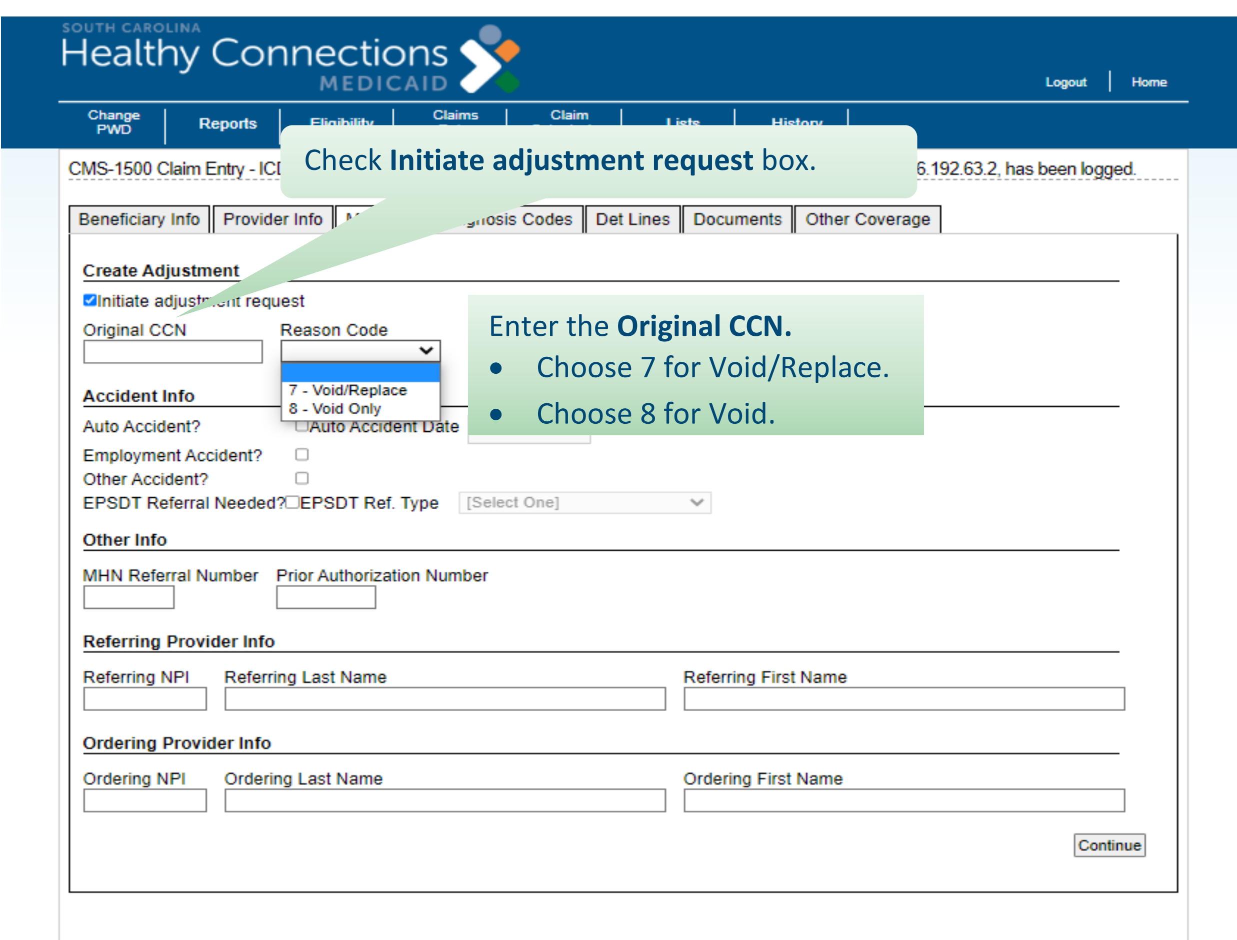


Do not file adjustments on the Form 130. Submit the UB-04 in the same medium as the original claim.

Web Tool Adjustments - 1500

To file a CMS-1500 adjustment over the Web Tool:

SOUTH CAROLINA
Healthy Connections
MEDICAID
Please select a provider to work with:
Select
Logout | Home
Change PWD | History
Click on Enter New Claim.
CMS-1500 Pending Claims
Enter New Claim | Copy Sel. | Delete Sel. | View Sel. | Search Name

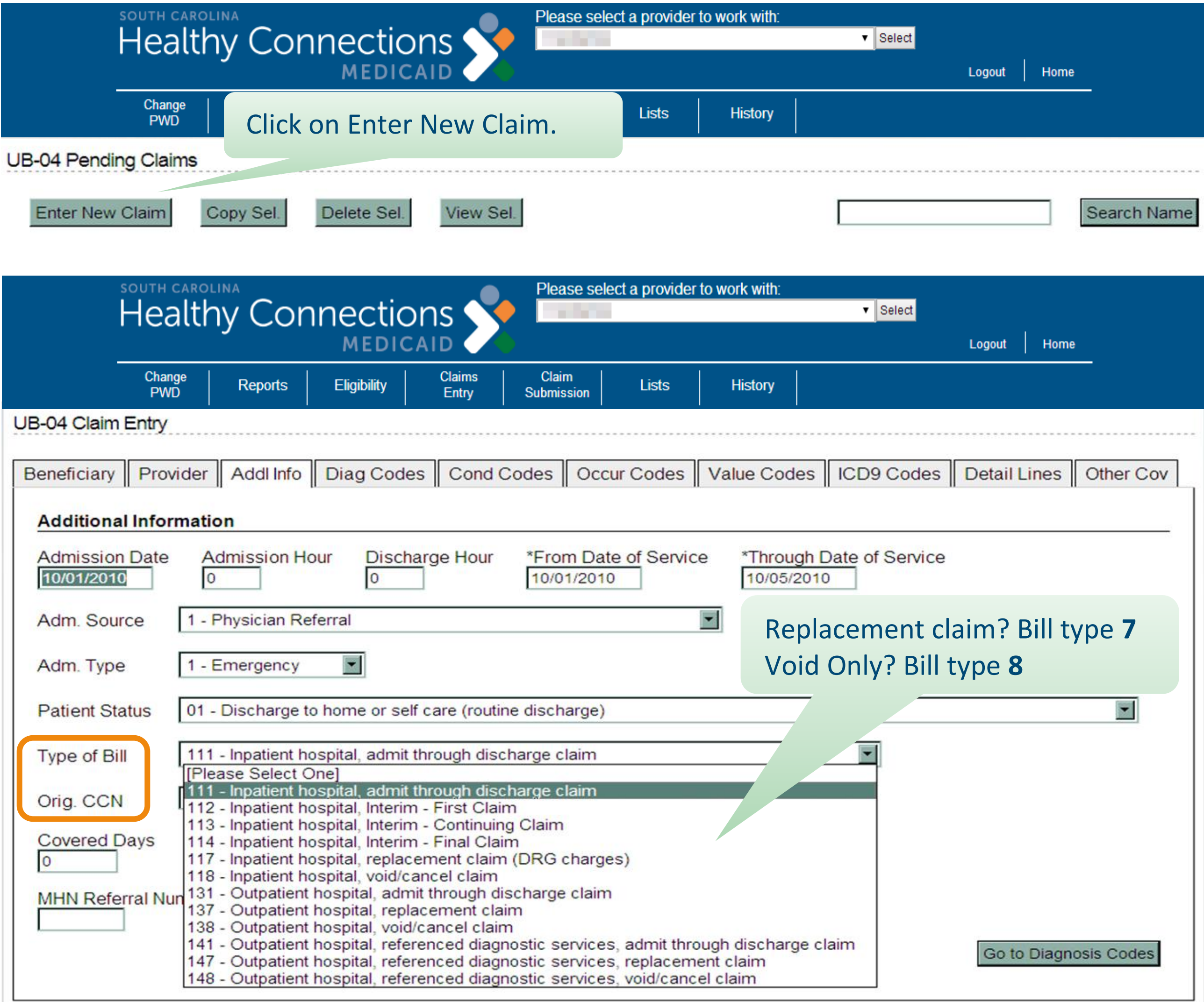


Quick tip: Copy the claim, correct it, and save it for submission.

- Only applies to: CMS-1500 Void/Replacement claims - still active in the Web Tool files
- Otherwise: Enter your corrected line detail information on the CMS-1500 Detail Lines tab.

Web Tool Adjustments – UB04

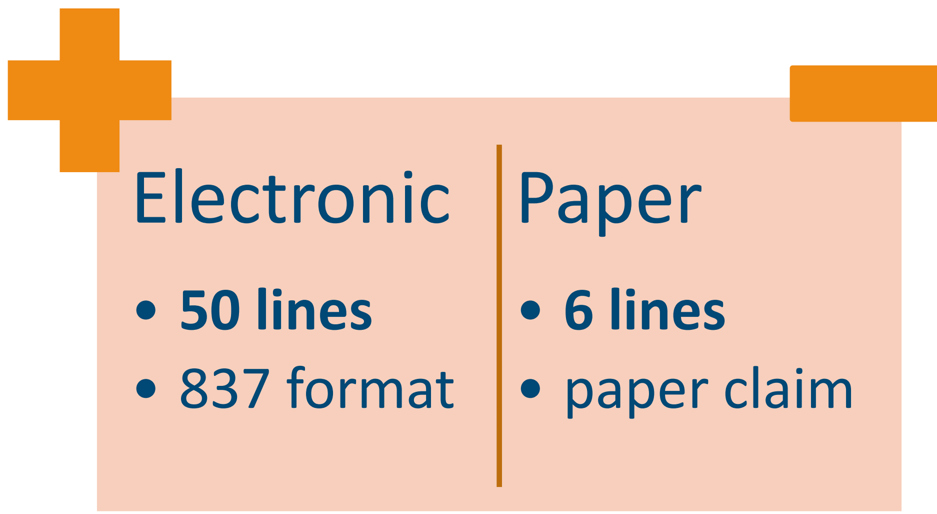
You can copy and fix any claim you have filed on the Web Tool within the last 3 months. You simply change your type of bill code.



Remember, if you find that a recipient has other insurance, you would file this information as a void/replacement. Also, you don't need to send in the EOB for TPL payments to be adjusted online.

Detailed Line Limitations

When adjusting, be aware of your line limitations.



Action: Your original CMS-1500 (837) **electronic** claim has 13 lines of detail. You attempt a claim-level void/replacement using **paper**.
Result: All 13 lines are recouped, but only 6 replacement lines are processed. (The claim is returned to you indicating the exceeded line limits.)

Paper claim adjustments are limited.

		Adjustment Claim	
		Electronic	Paper
Original Claim	Electronic	✔	Only replaces 6 lines (of the potential 50 electronic lines)
	Paper	✔	✔

Edit Codes

534 Provider number does not match

- Provider number on Form 130 does not match provider number on original claim to be voided.
- If providers receive this error, verify the correct provider number was submitted on Form 130.
  - If the provider number is incorrect, submit a new Form 130 with the correct provider number.
  - If the provider number is correct on Form 130, verify claim control number of original claim.
  - If the Claim Control Number is incorrect, submit a new Form 130 with the correct CCN.

575 Claim not found on Medicaid's active history data base (Claim number and Recipient ID must match)

- Claim number and/or recipient I.D. on Form 130 does not match number(s) on original claim to be voided.
- If providers receive this error, verify correct Claim Control Number and/or recipient I.D. were submitted on the Form 130.
  - If the number(s) is incorrect, submit a new Form 130 with the correct number(s).
  - If claim number and recipient I.D. are correct on Form 130, contact the Provider Service Center (PSC).

867 Duplicate Adjustment (Original claim already voided)

- Claim Control Number on Form 130 was previously voided.
- If CCN is incorrect, submit new Form 130 with corrected information.
- If CCN is correct, no further action is needed.

561 Retro Medicare-Debit Request in Process

- Beneficiary was eligible for Medicare at date of service - recoupment request is in process
- DHHS has identified the need for an adjustment and has already debited provider's account or is scheduled to adjust in the near future.

562 Retro Health-Debit Request in Process

- DHHS has identified the need for an adjustment (In-patient/Out-patient Institutional, Nursing Home and Ambulance Medical Transportation).
- Recipient was covered by other insurance carrier at date of service
  - a debit adjustment will occur if SCDHHS does not receive a refund check or if MIVS does not receive appropriate information.

563 Pay & Chase-Debit Request in Process

- DHHS has identified the need for an adjustment.
- SC Medicaid paid claim due to type of care
  - a debit adjustment will occur if SCDHHS does not receive a refund check or if MIVS does not receive appropriate information.

568 Corresponding adjustment (Void) is suspended or denied

- Replacement claim will suspend or deny when the Void claim fails to process.
- Determine if Void "U" claim processed incorrectly.
  - If Void "U" claim processed incorrectly, resubmit corrected Form 130 with Replacement claim.

569 Original CCN is invalid on adjustment claim

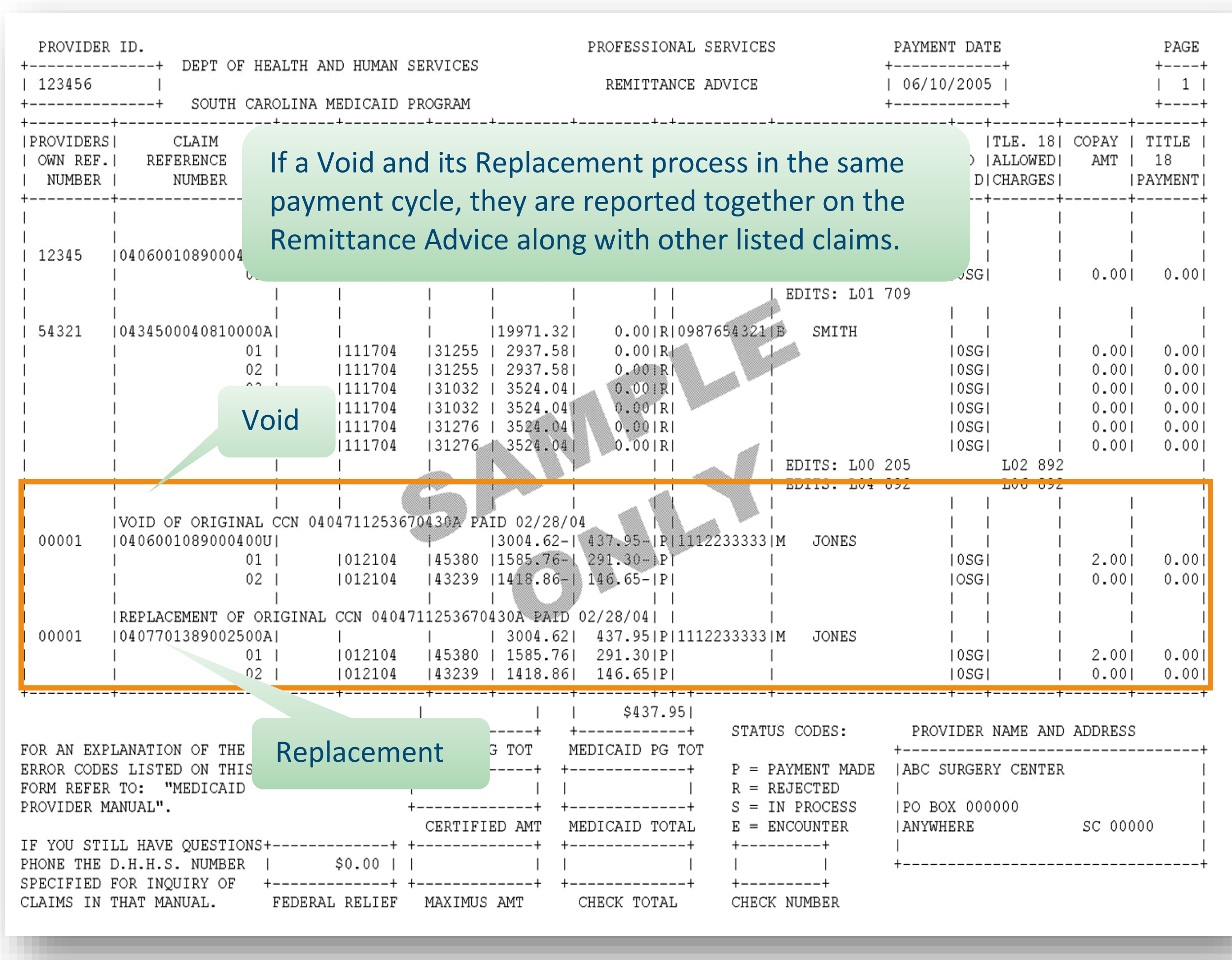
- Form 130 cannot be submitted to void a "U" claim.

Adjustments on the Remittance Advice

The original Claim Control Number and other claim details appear on both the void and replacement lines.

Sample: Void/Replacement (same payment cycle)

This sample shows two rejected claims, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.



```
 PROVIDER ID.                                         PROFESSIONAL SERVICES          PAYMENT DATE                  PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                  +------------+                +----+
| 123456       |                                      REMITTANCE ADVICE              | 06/10/2005 |                |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                   +------------+                +----+
|PROVIDERS|      CLAIM                                                             |TLE. 18| COPAY | TITLE |
| OWN REF.|    REFERENCE                                                          |ALLOWED|  AMT  |  18   |
|  NUMBER |      NUMBER                                                          D|CHARGES|       |PAYMENT|
| 12345   |04060010890004                                                     SG|       |  0.00|  0.00|
|         |                                               | EDITS: L01 709
| 54321   |0434500040810000A|       |        |19971.32|    0.00|R|0987654321|B   SMITH
|         |              01 |111704 |31255 | 2937.58|    0.00|R|            |0SG|       |  0.00|  0.00|
|         |              02 |111704 |31255 | 2937.58|    0.00|R|            |0SG|       |  0.00|  0.00|
|         |                 |111704 |31032 | 3524.04|    0.00|R|            |0SG|       |  0.00|  0.00|
|         |                 |111704 |31032 | 3524.04|    0.00|R|            |0SG|       |  0.00|  0.00|
|         |                 |111704 |31276 | 3524.04|    0.00|R|            |0SG|       |  0.00|  0.00|
|         |                 |111704 |31276 | 3524.04|    0.00|R|            |0SG|       |  0.00|  0.00|
|         |                                               | EDITS: L00 205        L02 892
|         |VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04
| 00001   |0406001089000400U|       |        |3004.62-| 437.95-|P|1112233333|M   JONES
|         |              01 |012104 |45380 |1585.76-| 291.30-|P|            |0SG|       |  2.00|  0.00|
|         |              02 |012104 |43239 |1418.86-| 146.65-|P|            |OSG|       |  0.00|  0.00|
|         |REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04|
| 00001   |0407701389002500A|       |        | 3004.62|  437.95|P|1112233333|M   JONES
|         |              01 |012104 |45380 | 1585.76|  291.30|P|            |0SG|       |  2.00|  0.00|
|         |              02 |012104 |43239 | 1418.86|  146.65|P|            |0SG|       |  0.00|  0.00|
                                                  $437.95|
                                   G TOT    MEDICAID PG TOT    STATUS CODES:      PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                                                         +-----------------------------------+
ERROR CODES LISTED ON THIS                                     P = PAYMENT MADE   |ABC SURGERY CENTER                 |
FORM REFER TO:  "MEDICAID                                      R = REJECTED       |                                   |
PROVIDER MANUAL".                                              S = IN PROCESS     |PO BOX 000000                      |
                               CERTIFIED AMT  MEDICAID TOTAL   E = ENCOUNTER      |ANYWHERE              SC 00000     |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+ +-------------+ +---------+  |                       |
PHONE THE D.H.H.S. NUMBER  |       $0.00 | |             | |             | |         |  +-----------------------------------+
SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+ +-------------+ +---------+
CLAIMS IN THAT MANUAL.      FEDERAL RELIEF   MAXIMUS AMT     CHECK TOTAL    CHECK NUMBER
```

This is in addition to being reported in the Void Only section of the RA.

```
PROVIDER ID.                                             CLAIM ADJUSTMENTS          PAYMENT DATE      PAGE
AA8888          DEPT OF HEALTH AND HUMAN SERVICES                                   03/26/2004        2
                SOUTH CAROLINA MEDICAID PROGRAM
```

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	FI	MI	MOD	ORG CHECK DATE	ORIGINAL CCN
TSS888888	0406001089000400U				513.00-	197.71-		9999999999	LARK	M			022804	0404711253670400A
	01		012104	A0425	453.00	160.71-	P					OHH		
	02		012104	A0434										
TSS888888	0406001090000401U				5									70400A
	01		012104	A0425	4									
	02		012104	A0434										
	VOID OF ORIGINAL CCN 0404711253430A PAID 02/28/04													
TSS888888	0406001101020400U				1412.00-	273.71-		9999999999	LARK	M			022804	0404711253670430A
	01		012104	A0425	1112.00-	143.71-	P					OHH		
	02		012104	A0434	300.00-	130.00-	P					OHH		
	TOTALS		3		1539.00-	593.13-								

Also reported with its Replacement in the Paid Claims section (or first part of) the RA.

Even though the Void is reported twice, the money is only voided and taken back once.

```
                                                               FEDERAL RELIEF      TO BE REFUNDED
                                                                                   IN THE FUTURE
                                                               0.00
REMITTANCE                                                                         0.00
0.00                ADJUSTMENTS         MAXIMUS AMT
                    0.00                                       PROVIDER NAME AND ADDRESS
YOUR CURRENT                                                   MOOD        MED CTR
DEBIT BALANCE       CHECK TOTAL         CHECK NUMBER
593.13              0.00                                       PO BOX 100000
                                                               ADDRESS                SC 20000
```

Sample: Void/Replacement (not same payment cycle)

There will be times when the Void and Replacement claims do not process during the same payment cycle. When this occurs, they will be reported on separate RAs.

\# AAB888 MOOD MED CTR — PO BOX 100000 — ADDRESS — SC 20000

.29500000000 . Y

PROVIDER ID.: AAB888

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 03/26/2004

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
TSS888888	0406001089000400A				1192.00	243.71	P	9999999999	M LARK			0.00	
	01		021504	A0428	800.00	117.71	P			OHH			0.00
	02		021504	A0425	392.00	126.00	P			OHH			0.00
TSS888888	0406001101020400A				12.00-	273.71-		9999999999	M LARK				
	01		012104	A0425	1112.00-	143.71-				OHH			
	02		012104	A0434	300.00-	130.00-				OHH			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
TSS888888	0407701389002500A				1001.50	42.75	P	9999999999	M LARK			0.00	
	01		012104	A0425	142.50	42.75	P			OHH			0.00
	02		012104	A0434	859.00	0.00	R			OHH			0.00
	TOTALS		2		2193.50	286.46						0.00	0.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TO[illegible]: $0.00

CERTIFIED A[illegible]

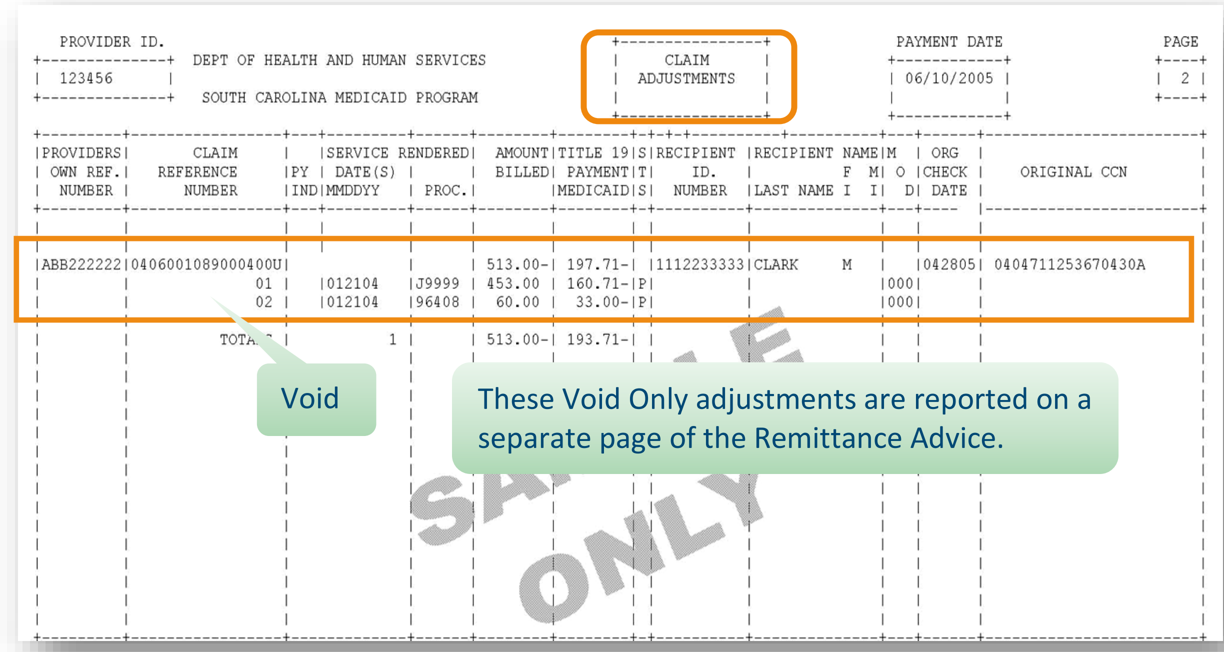
FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER
$0.00	$0.00	0.00	

Replacement

The Void would have been reported on a previous RA since the Replacement claim cannot process until the Void had processed.

Sample: Claim-level void

Claim-level adjustments are reported with corresponding detail information. (This sample shows a claim-level Void without a corresponding Replacement claim.)

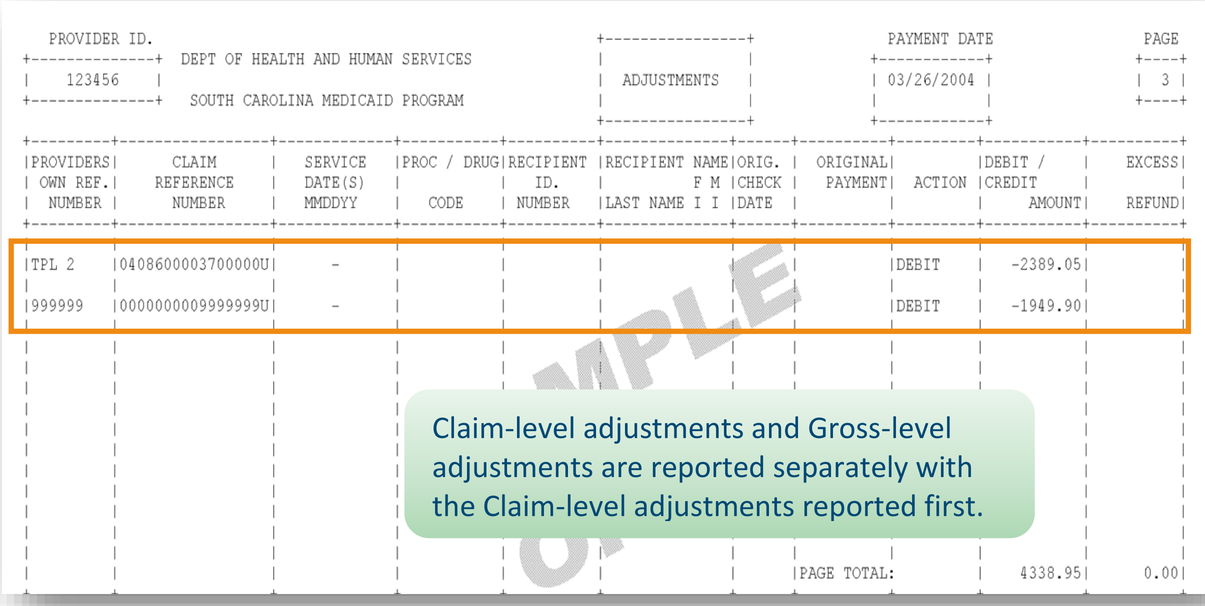


PROVIDER ID. 123456 — DEPT OF HEALTH AND HUMAN SERVICES — SOUTH CAROLINA MEDICAID PROGRAM — CLAIM ADJUSTMENTS — PAYMENT DATE 06/10/2005 — PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F I M I	MOD	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK M		042805	0404711253670430A
	01		012104	J9999	453.00	160.71-	P			000		
	02		012104	96408	60.00	33.00-	P			000		
	TOTA		1		513.00-	193.71-						

Sample: Gross-level adjustment

Gross-level adjustments always appear on the final page of the Remittance Advice.



PROVIDER ID. 123456 — DEPT OF HEALTH AND HUMAN SERVICES — SOUTH CAROLINA MEDICAID PROGRAM — ADJUSTMENTS — PAYMENT DATE 03/26/2004 — PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F I M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	0408600003700000U	-						DEBIT	-2389.05	
999999	0000000009999999U	-						DEBIT	-1949.90	
							PAGE TOTAL:		4338.95	0.00