Healthy Connections *Visual*

MEDICAID BASICS BOOK

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 July 2024

SOUTH CAROLINA Healthy Connections MEDICAID

Contents

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.

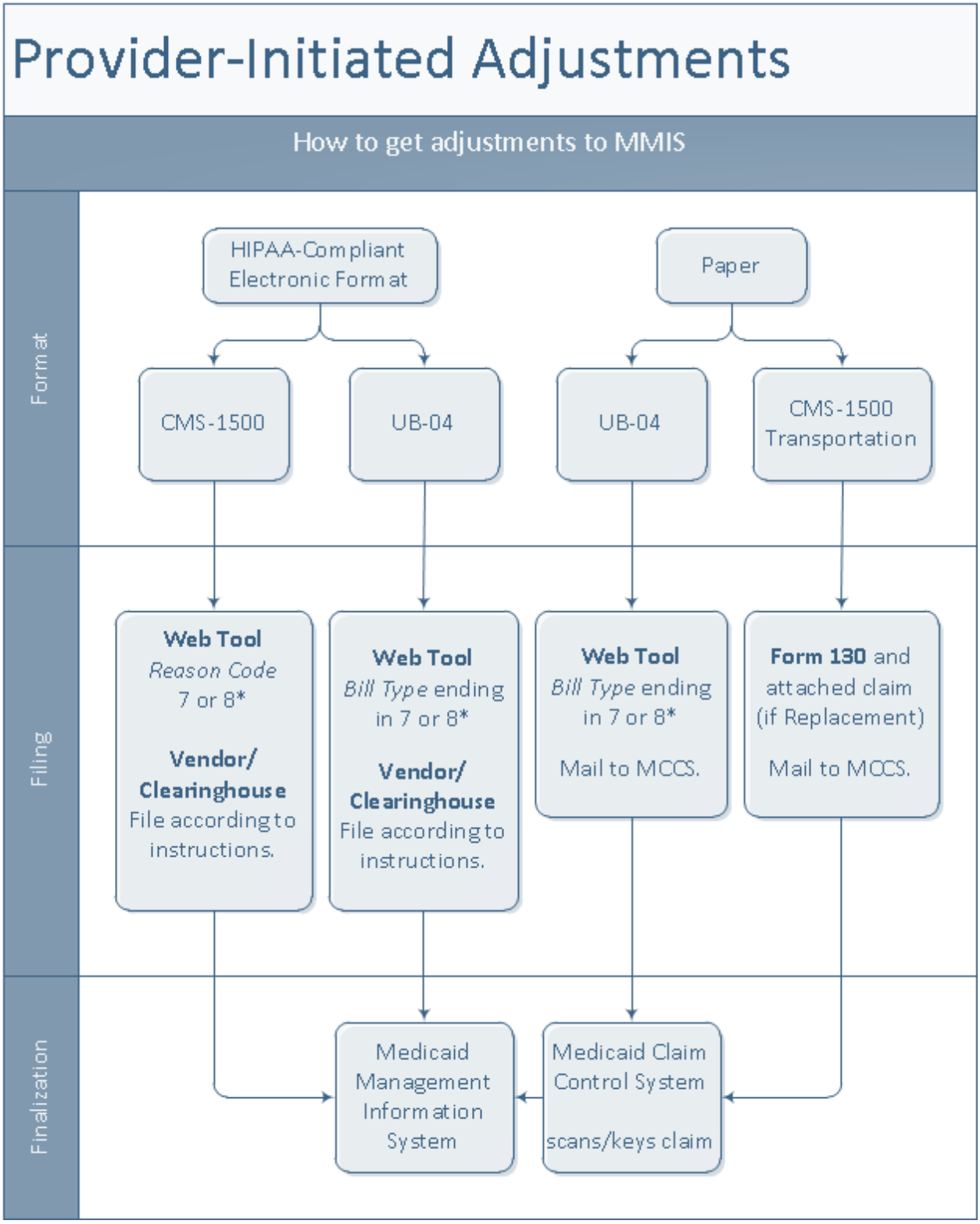
	Gross-Level Adjustment	Claim-Level Adjustment
Definition	A debit or credit initiated by South Carolina Medicaid	A Void or Void/Replacement initiated by provider or Medicaid
Scope	• Not tied to a particular claim or member • Can adjust multiple claims at one time	• Tied to a particular claim or member • 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 Member 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 member 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.

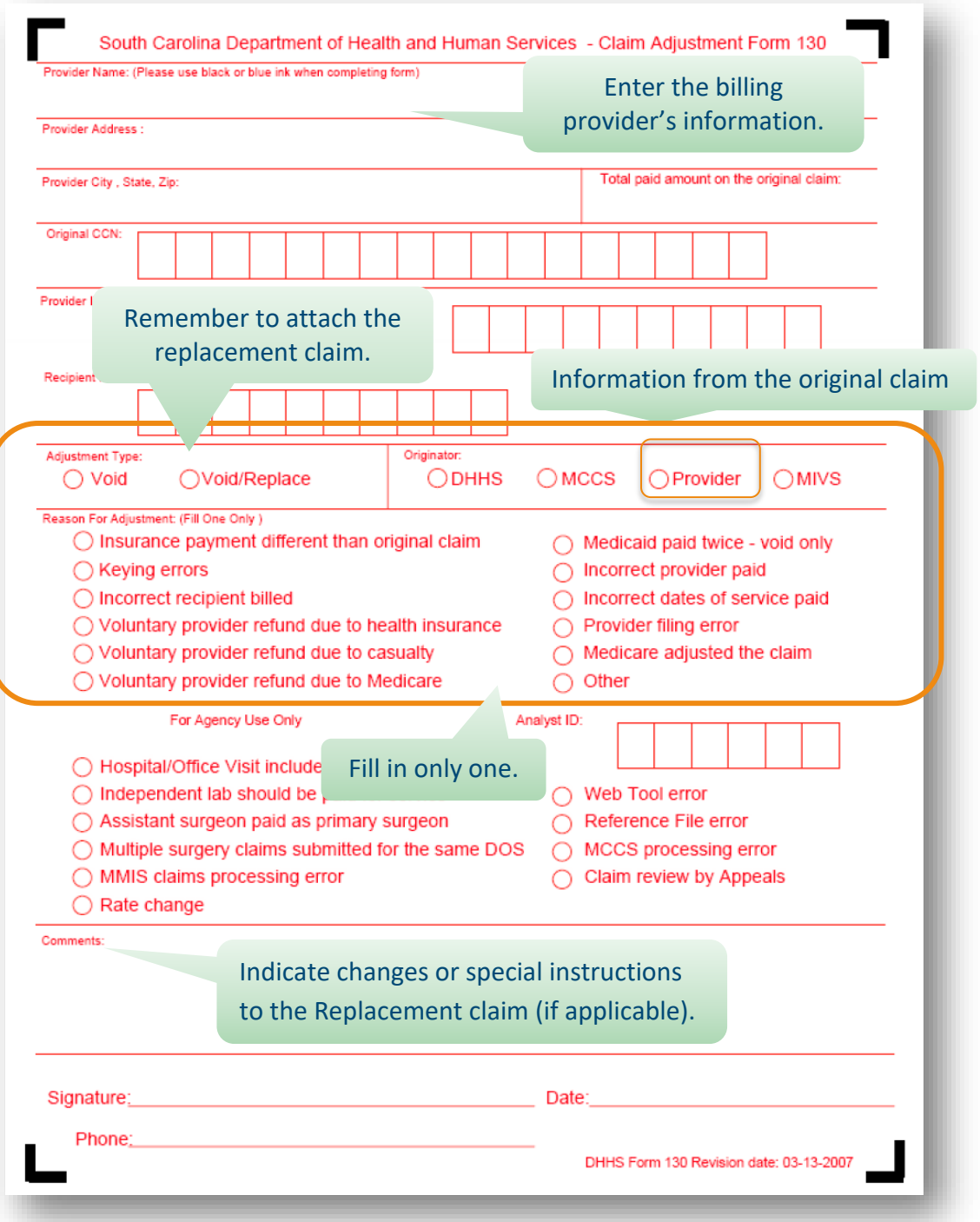
Adjustment Process



*7 = Void; 8 = Void/Replacement

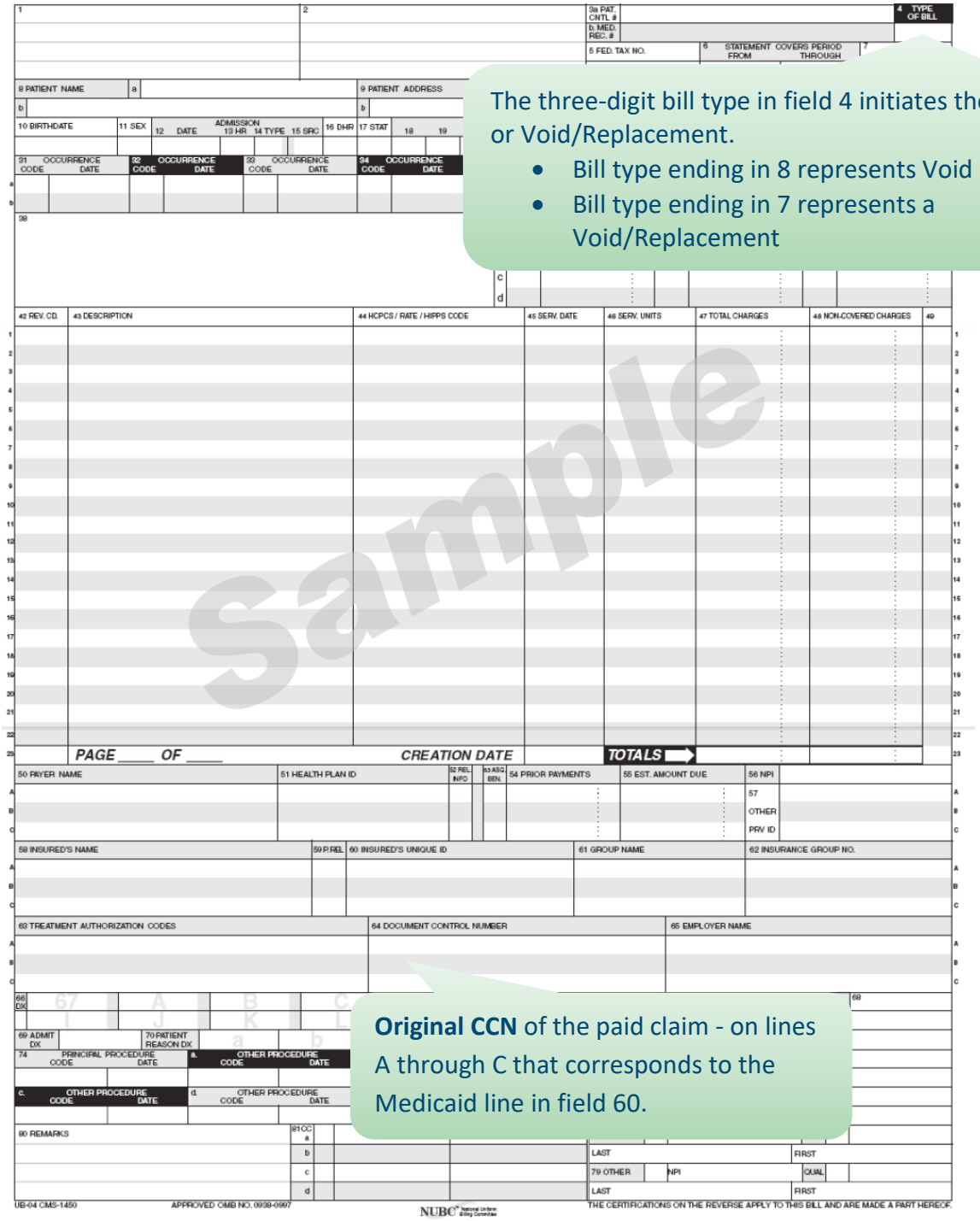
Form 130

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 Member ID as the original claim.
SCDHHS Form 130 – Claim-level Adjustments



UB-04 Adjustments

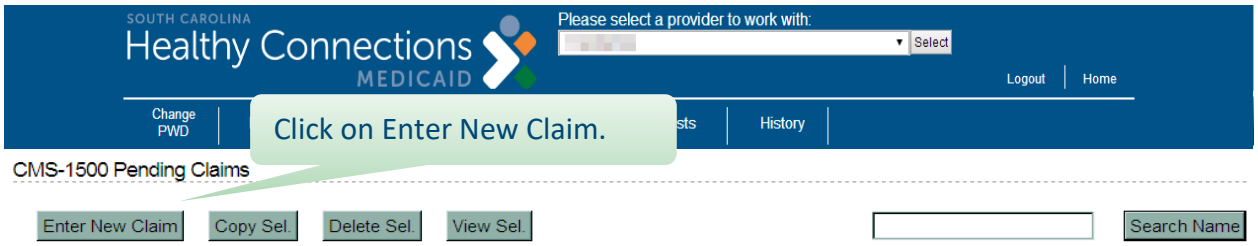
A UB-04 is used to process Void and Void/Replacements on institutional paper claims.

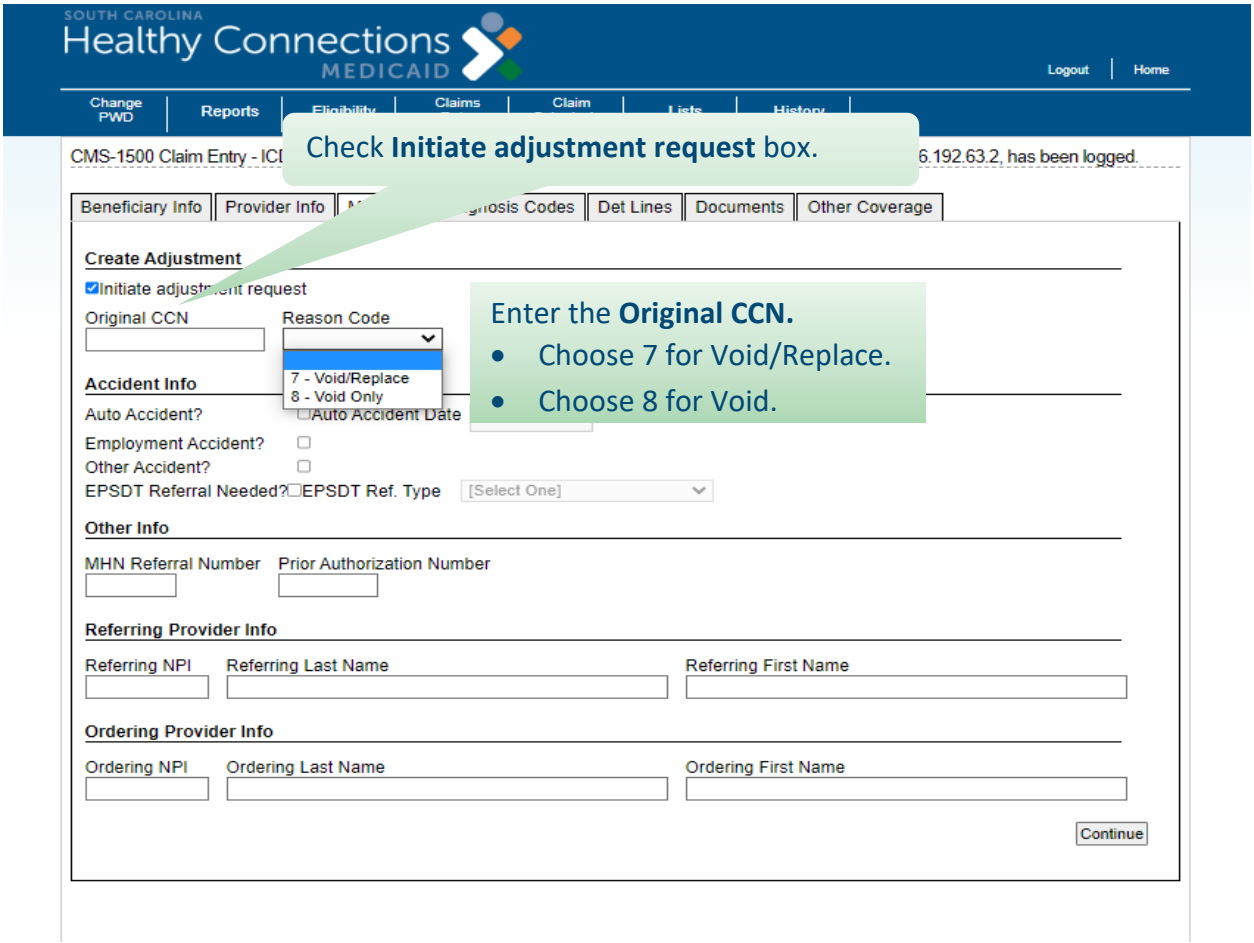


Do not file adjustments on the Form 130. Submit the UB-04 in the same medium as the original claim.

Web Tool Adjustments - 1500

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



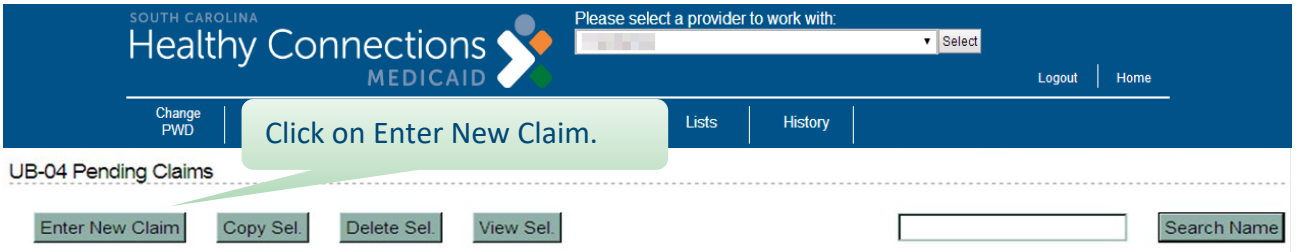


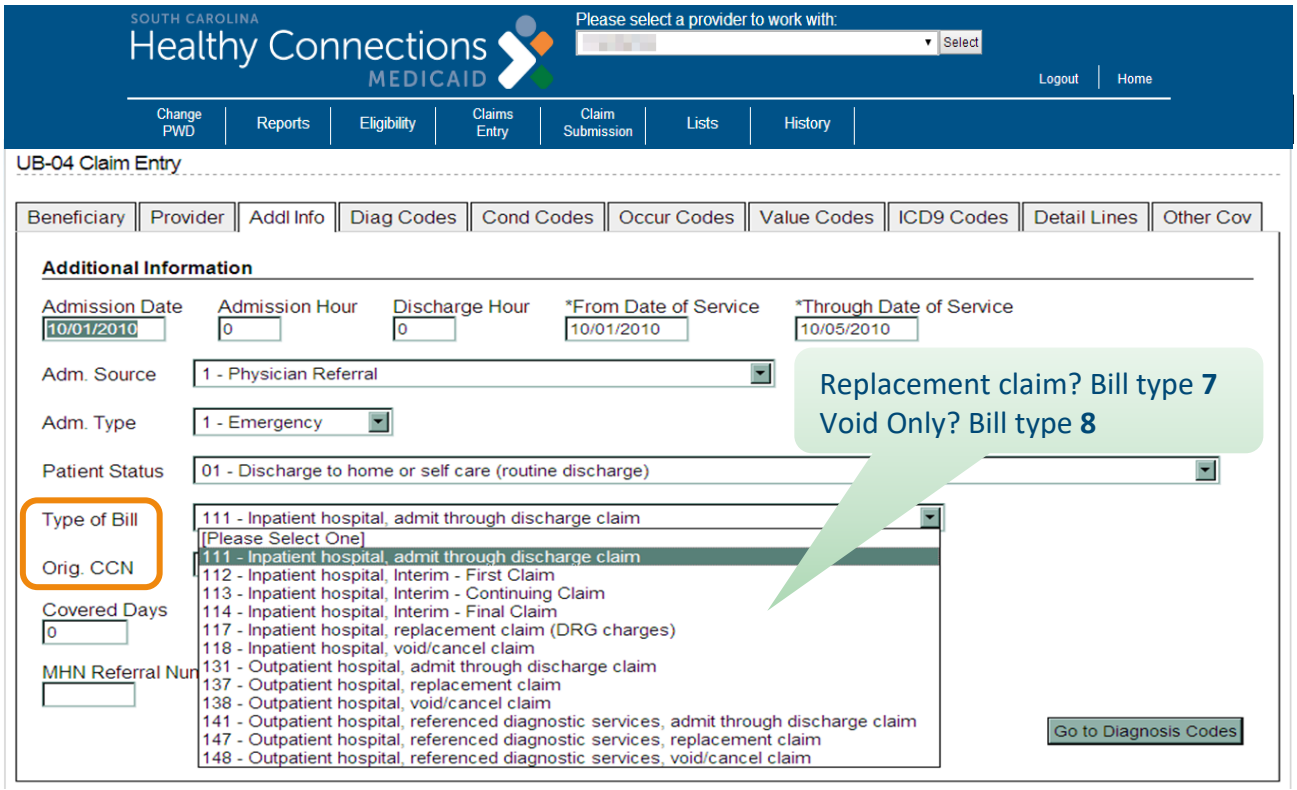
Quick tip: Copy the claim, correct it, and save it for submission.

- 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.

Electronic	Paper
• **50 lines**	• **6 lines**
• 837 format	• paper claim

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 Member ID must match)

- Claim number and/or member 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 member 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).
- Member 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

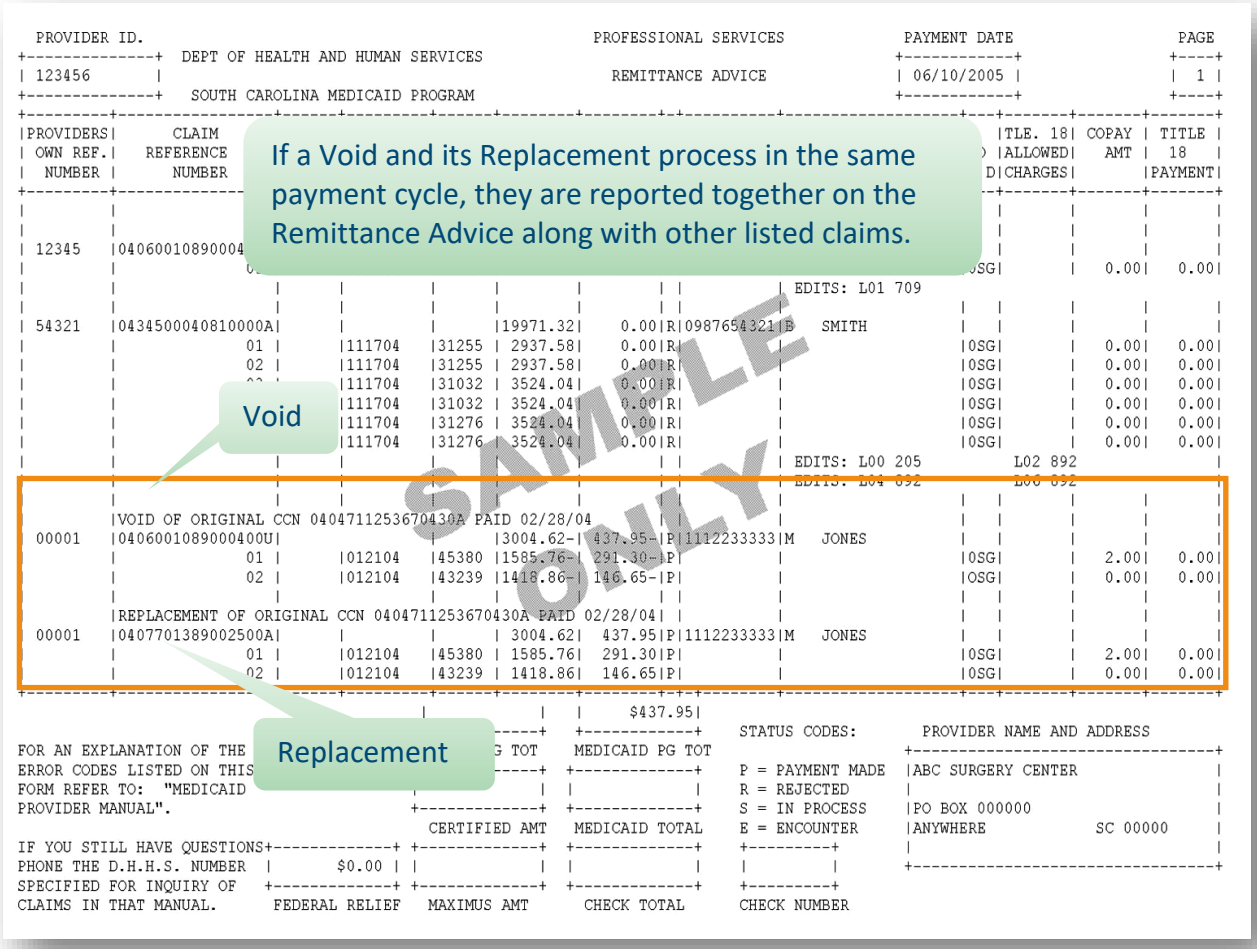
- Form 130 cannot be submitted to void a "U" claim.

Adjustments on the Remittance Advice

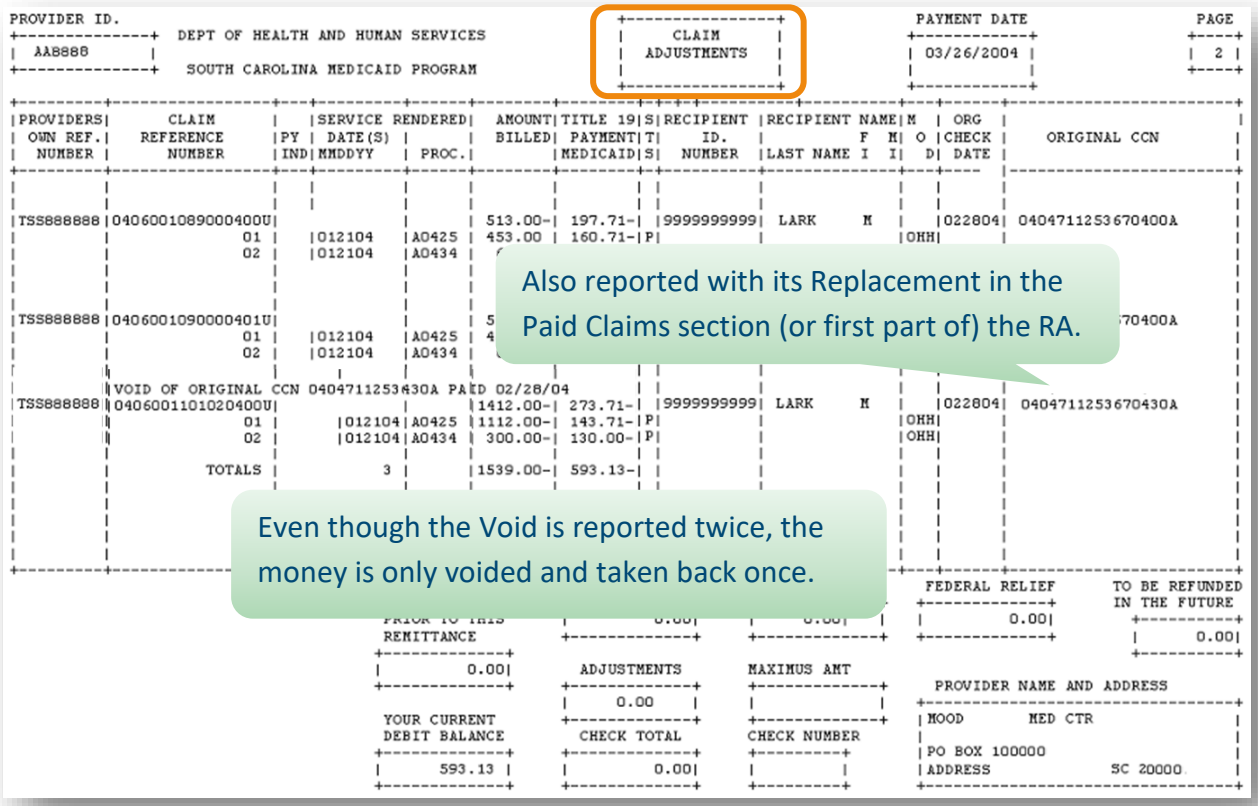
The original Claim Control Number and other claim details appear on both the void and replacement lines.

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.

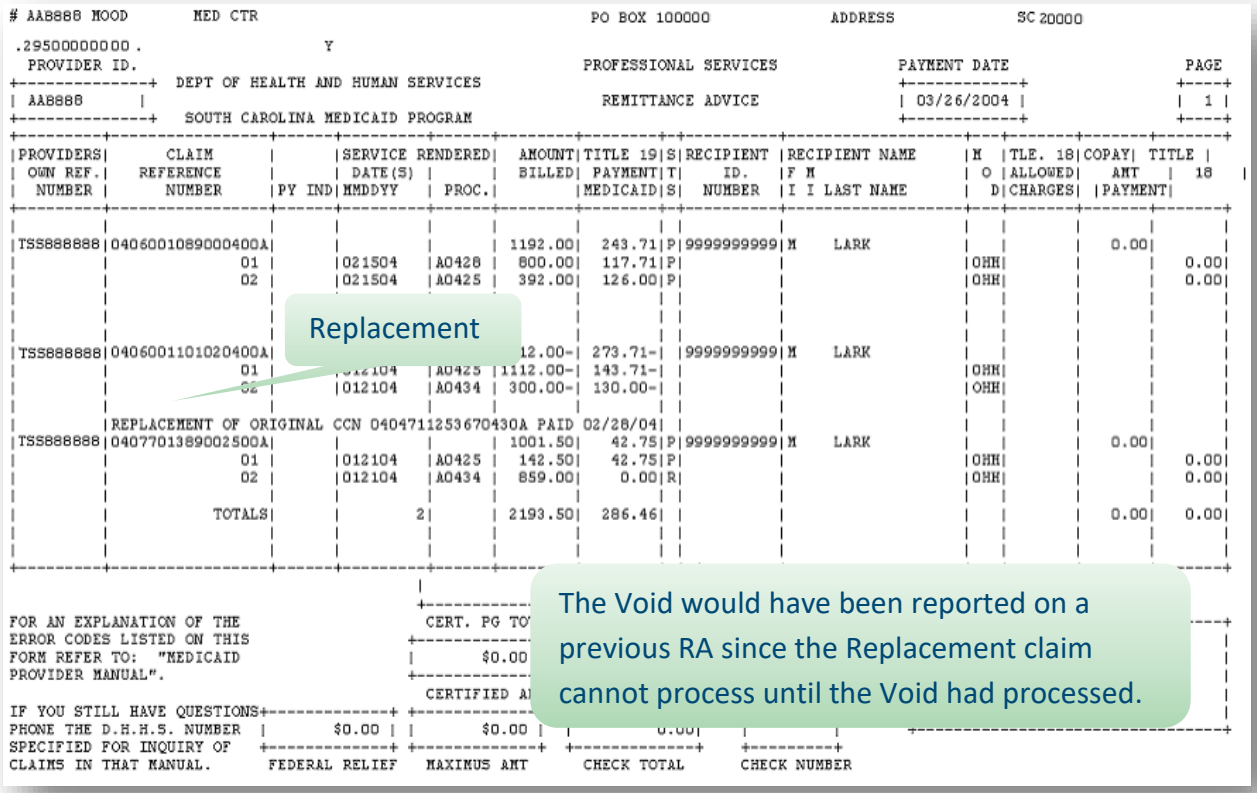


This is in addition to being reported in the Void Only section of the RA.



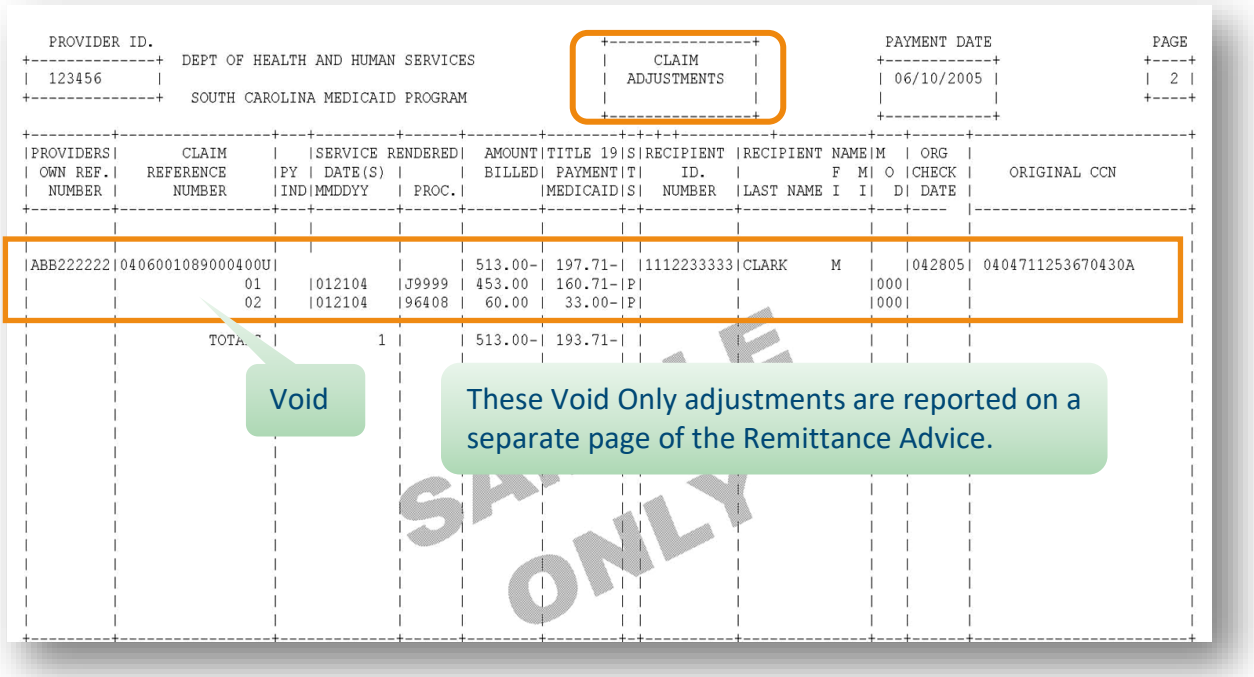
Sample: Void/Replacement (not same payment cycle)

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.



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.)



Sample: Gross-level adjustment

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