Overview

• General Information
• Methods
• Remittance Advice
• Claims Status
• Additional Information
General Information
Adjustments

An adjustment is a method used to correct a previously paid claim

• Adjustments are used for a paid claim that should remain in place, but needs minor corrections or adjustments
  – For example, when:
    • A procedure code, revenue code, charges or number of days billed needs correcting
    • A third party resource pays/recoups reimbursement for the claim
    • An update to service authorization (SA) occurs

• You may only adjust paid claims, not fully denied or in-process claims
  – Paid claim may have one or more denied lines as long as the status is P

• Resubmit the entire claim as you want it to adjudicate
  – Submitting only the line(s) to be adjusted will cause all previously paid non-adjusted lines to be voided because the system sees the missing lines as part of the adjustment reason
A void is a method used to reverse a previously fully adjudicated claim

• Providers must request to void a claim submitted with incorrect information, including:
  – Wrong Member ID number
  – Wrong Medicaid Contract ID number
  – Services not rendered
  – Duplicate payments
• Any claim with a status of P, O, or C may be voided
  – Suspended and Denied claims cannot be voided
• If a provider bills Alaska Medicaid prior to billing Medicare for dual-eligible members, the claim must be voided and rebilled to Medicare to ensure proper adjudication through both agencies
  – Exception: if all procedure codes on the claim are non-covered by Medicare, the provider may bill Alaska Medicaid directly
• Timely filing restrictions do not apply to void requests

Claims Status Codes are:

- P – Paid
- D – Denied
- S – Suspended
- O – To Be Paid
- C – To Be Denied
Overpayments & Repayment of Payment Errors

Providers should closely review each remittance advice (RA) to ensure it reflects accurate payment for all billed services, including correct member details and services provided.

– In accordance with 7 AAC 105.220(e), Alaska Medical Assistance providers have 30 days from the time of payment to notify the department in writing of a payment error.

– Federal law (42 U.S.C. 1320(d)) requires repayment of overpayments to the department within 60 days of identifying the overpayment.

– Mail the written overpayment notification and a copy of the RA page detailing the overpayment to the address below:

  Conduent State Healthcare, LLC
  P.O. Box 240807
  Anchorage, Alaska 99524-0807
Recordkeeping

- Recordkeeping requirements are documented in the Individual Provider Agreement and Tax Certification and Group Provider Agreement and Tax Certification.
- Although most recordkeeping requirements are consistent for all providers, some requirements are provider-type specific.
- Providers must maintain complete and accurate clinical, financial, and other relevant records to support the care and services for which they bill Alaska Medicaid for a minimum of 7 years from the date of service.
- Records of adjustments and voids also need to be maintained as part of the provider’s financial records.
- Providers are subject to audits, reviews, and investigations.
- Providers must ensure their staff, billing agents, and any other entities responsible for any aspect of records maintenance meet the same requirements.
Methods
Providers may submit adjustments and voids through Health Enterprise.

- The original claim must have been submitted using Health Enterprise
- Select *Create Claims*, then the correct claim type

- Select Yes under “Is this a void/replacement of a previously processed claim?”
- Specify *Void* or *Replacement* (adjustment) and enter the claim TCN
For those using a pre-tested billing software, adjustments and voids can be processed using an 837 transaction

- **837 - Healthcare Claim Forms**
  - Professional (837P)
  - Institutional (837I)
  - Dental (837D)
  - Retail pharmacy – National Council for Prescription Drug Programs

- Each must include the original Internal Control Number

- Claim Submission Reason Code
  - Enter either 7 (adjustment) or 8 (void)

- Refer to the applicable TR3 for further guidance
Attachments

• Some claims require supporting documentation, such as:
  – Explanation of Benefits from other insurance
  – Medical records or clinical documentation
  – Consent forms

• Any attachments that applied to the original claim should also be sent with the adjustment request

• When adjusting using an AK-05, attachments must be sent with the form

• When adjusting electronically, attachments must be faxed the same day the adjustment is submitted

• For electronic billing, an attachment control number must be:
  – Entered into the electronic claim
  – Written on the attachment(s)
  – Documented on the fax attachment cover sheet
Attachment Fax Cover Sheet
The Adjustment/Void Request Form (AK-05) may be used to:

- Change (adjust) a claim that was billed or processed incorrectly, including individual lines
- Void a claim
- Repay an overpayment
  - The provider can choose one of two refund methods:
    - Complete field 4, and include a check for the correct refund dollar amount made payable to the State of Alaska
    - Submit without a refund check and allow the money to be automatically deducted from a subsequent Alaska Medicaid payment(s)
- The AK-05 form can be used to request an adjustment or void regardless of how the initial claim was submitted

Adjustments: Each AK-05 submitted for an adjustment should have an original complete, corrected claim attached that includes all lines to be considered for payment, even if the original line(s) was paid, and a copy of the page of the remittance advice indicating its Paid adjudicated status. Suspended claims cannot be adjusted.
Indicate Adjustment or Void

If reimbursing an overpayment, indicate the amount, select Refund, and enter the Check No.

Mail to:
Conduent State Healthcare, LLC.
P.O. Box 240807
Anchorage, Alaska 99524-0807
Refund Amount

• When your adjustment or void will result in money being refunded to AK Medicaid, you can either submit a check payable to “State of Alaska” or simply submit your AK-05 with adjustment or void and the amount will be recouped on the RA for the week in which it is processed.
• If you are submitting a check, it is important to make it out for the correct amount.
  – If you are voiding a claim, the amount should be for the total reimbursed amount paid on that claim, less any previous adjustment amounts.
  – If you are removing a line, the amount should be the amount paid on that line only.
  – If you are correcting for a TPL payment, the amount should be for the amount the TPL paid, not to exceed the Medicaid allowable or paid amount, whichever is less.
For example:

- If you are voiding this claim, the refund amount should be $504.78
- If you are removing a line – in this example, the 2nd line of the claim – the refund amount should be $4.62
- If you are correcting for a TPL payment, the amount should be for the amount TPL paid, not to exceed the Medicaid paid amount
  - If TPL paid $120 toward line 5 of this claim – the refund amount should be $120.00
  - If TPL paid $1,200 toward line 5 of this claim – the refund amount should be $469.24
Remittance Advice
A Remittance Advice is a notice of payments and adjustments for providers.

- Once a claim has been received and accepted, it is processed and the appropriate payment is determined
- Informs provider of submitted claims status
  - Adjudicated claims (paid and denied): Claims adjudication in health insurance refers to the determination of an insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim
  - In-process claims
  - Adjusted and voided claims
Electronic Transaction Types

835 – Electronic Remittance Advice
• If you are submitting HIPAA compliant 837 transactions, you may receive an 835 transaction as a response

You might notice some differences:
• Remark codes returned on an 835 will be HIPAA compliant v5010 X12 remark codes rather than the 4-character Health Enterprise codes
  – These codes can be found in your TR3 guides
• Only one transmission is available - providers must indicate if they want to receive the 835 or if it should be sent to their billing agent
• The appearance of the 835 will vary depending on the provider’s software

Provider Notice: If using practice management software, it is your (or the billing agent’s) responsibility to be able to interpret 835 remark codes. The Provider Inquiry dept. does not have that capability.
• TR3 guides are available for purchase from www.wpc-edi.com
Remittance Advice Sections

Processed adjustments appear in two parts on the RA

- **Credit**: Alaska Medical Assistance receives a credit by taking back the money that was previously paid
  - Credit TCNs will end in a 2

- **Debit**: Alaska Medical Assistance debits the new amount to pay the replacement claim
  - Debit TCNs will end in a 3

Processed voids appear in a separate section of the RA

- **Void**: Alaska Medical Assistance deducts full claim amount (dollars and units) from payment history, provider and member files, and any associated service authorization as well as a reduction in the claims paid year-to-date dollar amount in the summary
  - A voided claim will result in a provider overpayment; the amount listed in the RA should be reviewed for accuracy
  - Void TCNs will end in a 1
## Adjustment Claims

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**Adjust TCN:** 1418830000000010

**Claims:**
- Total Adjusted Claims: 12
- Total Lines: 813
- TPL: $10.00
- Patient Liability: $0.00
- CO-Payment: -$1,813.38

**Billed Amounts:**
- $26,312.40
- $2,674.56
- $25,637.84

**Payment Amounts:**
- $26,312.40
- $2,674.56
- $25,637.84
# Adjustment Claims

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**Total Adjusted Claims:** 82  **Lines:** 813  **TPL:** $26,312.40  **-2,674.56**  **-25,658.56**
### Voided Claims

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**Total Voided Claims: 6**

**Line 85:**

| TPL: $0.00 | PATIENT LIABILITY: $0.00 | CO-PAYMENT: $0.00 | CONTRACTUAL: $0.00 | PAYMENT: $0.00 |

Run Date: 2/18/2015

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Additional Information
Additional Resources


- Information necessary for successful billing
- Includes provider-specific Medicaid billing manuals and fee schedules

You may also call:

- Provider Inquiry
  - Eligibility only – 907.644.6800, option 1,2 or 800.770.5650 (toll-free), option 1,1,2
  - Claim status and other inquiries – 907.644.6800, option 1,1 or 800.770.5650 (toll-free), option 1,1,1

- EDI Coordinator
  - Electronic transaction assistance – 907.644.6800, option 3 or 800.770.5650 (toll-free), option 1, 4
Disclaimer

The information contained in this presentation was current at the time it was written. It was prepared as a tool to assist providers and is not intended to be all inclusive, grant rights, impose obligations, or function as a stand-alone document. Although every reasonable effort has been made to assure the accuracy of the information within the presentation, the ultimate responsibility understanding Medicaid program regulations lies with the provider of services.

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