

### 471-000-99 Medicaid Claim Adjustment and Refund Procedures

This appendix outlines the procedures to request claim adjustments and refunds on processed Medicaid claims.

#### **MEDICAID CLAIM ADJUSTMENT REQUESTS:**

The claim adjustment process is only used on processed (paid or denied) Medicaid claims that were reported on the Medicaid Remittance Advice. The reason for the claim denial or payment reduction is reported on the Medicaid Remittance Advice (see 471-000-85). The claim adjustment request is used to request reconsideration of the payment or denial, correct information on the original claim, submit information or documentation missing from or required to pay the original claim, or correct information on the original claim.

Claim adjustment requests cannot be used to correct deleted, returned, or rejected Medicaid claims since these claims have not processed completely and were not reported on the Medicaid Remittance Advice. In these cases, a new claim must be submitted.

Providers must submit claim adjustment requests within 90 days of the payment/denial date on the Medicaid Remittance Advice, unless the claim adjustment request is related to third party health or casualty resources. Timelines for filing claim adjustment requests when third party resources are involved are in 471 NAC 3-004.06.

After the Department processes a claim adjustment request, the provider is notified of the decision. Denied adjustments are reported on the Electronic Claim Activity Report or on paper. Approved claim adjustments are reported on the Medicaid Remittance Advice when the adjustment results in a payment change or change to a data field reported on the remittance advice.

#### **HOW TO REQUEST CLAIM ADJUSTMENT:**

Providers may submit claim adjustment requests on paper or electronically. For pharmacy drug claims, the Point-of-Sale system is used. Instructions for each type of submission are outlined below. **Do not request an adjustment by submitting a new claim as this will result in denial as a 'duplicate' claim.**

#### **Paper Claim Adjustment Requests:**

1. Identify the paperwork as "Claim Adjustment Request;"
2. Identify the Medicaid claim to be adjusted –
  - If a copy of the Medicaid Remittance Advice is available, photocopy the page on which the claim appears and highlight in yellow or circle the Medicaid claim number;



- A voided claim is used when the identified claim will not be replaced. The voided claim will be processed for refund. Note: A voided claim should not be used for third party casualty cases (see 471 NAC 3-004.09); and
4. Provide the information supporting the adjustment request. Documentation may be submitted electronically or on paper. When submitting paper attachments, the transaction must include the Identification Code (referred to as the "Attachment Control Number") in the appropriate PWK segment –
- To correct information submitted on the identified claim, submit corrections as outlined in Step 3;
  - To provide additional documentation or to clarify services, submit appropriate documentation or justification; or
  - If the adjustment is needed due to denial for third party health or casualty resources, complete the Coordination of Benefits (COB) segments. If the COB information is not submitted electronically, the required documentation may be submitted as a paper attachment. For third party health resources, a copy of the health insurance remittance advice, explanation of benefits, denial, or letter is required. For third party casualty resources, a copy of the insurance explanation of benefits, payment check, letter from attorney, and similar documentation from the resource is required; and
5. Submit the adjustment request using your usual method for electronic claim submission. For additional information on submitting electronic transactions, see 471-000-50.

#### Pharmacy Drug Claim Adjustments:

Pharmacies submit drug claim adjustments through the Department's point-of-sale system by reversing the original claim and, if appropriate, submitting a rebill (new claim). Claim reversals may be submitted through the point-of-sale system within one year from the payment/denial date on the Medicaid Remittance Advice. If the claim can not be reversed through the point-of-sale system, the provider should contact the Department for assistance.

#### **MEDICAID REFUNDS:**

It is the responsibility of the provider to submit refunds to the Department upon discovering duplicate or erroneous Medicaid payments. The provider should not wait until a refund request is received from the Department before submitting refunds. Providers may refund the Department by submitting a check for the amount of the refund or by requesting a reduction to future payments (warrant reduction). Submission of a voided electronic claim will also initiate a refund request, but should not be used for third party casualty payment refunds (see 471 NAC 3-004.09). Pharmacies use the Department's point-of-sale system to process refunds on drug claims. Separate instructions are included for pharmacy drug claims.

When the provider receives payment from a third party resource on a claim previously paid by Medicaid, the provider must refund the Department within 30 days. If the third party payment equals or exceeds the Medicaid payment on the claim, the total Medicaid payment must be refunded. If the third party payment is less than the Medicaid payment on the claim, the total third party payment must be refunded.

The Department may also initiate requests for Medicaid refunds. Providers are notified of the refund request by letter, the Medicaid Remittance Advice "Refund Request" (Form MCP248), or the electronic refund request report. Providers have 30 days from the date on the notification to refund the Department. Providers may submit a check for the amount of the refund or request a reduction to future payments (warrant reduction) using the procedures in this appendix.

#### Submitting Refunds by Check:

Providers may initiate a refund or respond to a Department-requested refund request by submitting a refund check. After Department processing, providers will not receive notification of the refund on the Medicaid remittance advice.

1. Identify the paperwork as a "Refund;"
2. Identify the Medicaid claim being refunded –
  - If a copy of the Medicaid Remittance Advice is available, photocopy the page on which the claim appears and highlight or circle the Medicaid claim number; or
  - If a copy of the Medicaid Remittance Advice is not available, identify the Medicaid claim number, the client's Medicaid number, the Medicaid provider number, date of service, and claim charge;
3. Explain the reason for the refund and, if applicable, the service lines being refunded;
4. If the refund is due to payment by a third party resource, attach a copy of the third party remittance advice and, for third party casualty refunds, attach a copy of the check and accompanying documentation from the casualty resource, if available;
5. Attach a check for the amount of the refund. Note: Providers may submit refunds by returning a State of Nebraska warrant only if the warrant amount is equal to the full amount of the refund due;
6. Sign, date, and include the provider's telephone number on the refund submittal; and
7. Mail the refund submittal to:  
Department of Health and Human Services  
Medicaid Financial Support Unit  
P. O. Box 95026  
Lincoln, NE 68509-5026

#### Requesting Warrant Reduction:

Providers may initiate a refund or respond to a Department-requested refund by requesting a reduction to future payments (warrant reduction). After Department processing, the provider will receive notice of the warrant reduction on the Medicaid Remittance Advice (MCP248) or the standard electronic Health Care Claim Payment/Advice (ASC X12N 835) transaction.

To Request a Warrant Reduction by Phone: Contact DHHS at (402) 471-9176. Provide the Medicaid claim number, your Medicaid provider number, the client's Medicaid number, date of service, the refund amount and reason for refund.

To Request a Warrant Reduction on Paper:

1. Identify the paperwork as a "Warrant Reduction Requested."
2. Identify the Medicaid claim to be refunded –
  - If a copy of the Medicaid Remittance Advice is available, photocopy the page on which the claim appears and highlight or circle the Medicaid claim number; or
  - If a copy of the Medicaid Remittance Advice is not available, identify the Medicaid claim number, the client's Medicaid number, the Medicaid provider number, date of service, and claim charge;
3. Explain the reason for the refund and, if applicable, the service lines being refunded;
4. If the refund is due to payment by a third party resource, attach a copy of the third party remittance advice and, for third party casualty refunds, attach a copy of the check and accompanying documentation from the casualty resource, if available;
5. Sign, date, and include the provider's telephone number on the refund submittal; and
6. Mail the refund submittal to:  
Department of Health and Human Services  
Medicaid Financial Support Unit  
P. O. Box 95026  
Lincoln, NE 68509-5026

Initiating a Refund Request Electronically:

Providers may initiate a refund by submitting an electronic voided claim. See instructions for submitting electronic claim adjustments in the Medicaid Claim Adjustments section of this appendix. Note: This procedure should not be used for third party casualty payment refunds (see 471 NAC 3-004.09). After Department processing, a refund request will appear on the Medicaid Remittance Advice "Refund Request" (Form MCP248) or the electronic refund request report. The provider responds to the refund request by submitting a check for the amount of refund or requesting a warrant reduction.

Submitting Refunds for Pharmacy Drug Claims:

Pharmacies submit refunds on drug claims through the Department's point-of-sale system by submitting a reversal of the original claim. In some cases, a claim can not be reversed through the point-of-sale system and the pharmacy uses the procedure outlined for submitting refunds by check or by requesting a warrant reduction.