



**Hewlett Packard**  
Enterprise

**Rhode Island Medicaid**

# **BILLING 101 PART 3**

*Adjustments, Recoupments, and Refunds*

September, 2016

PR0081 V1.4



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# Billing 101

- Part 1 – The Basics

*For new providers seeking information on eligibility, claims forms and processing of claims*

- Part 2 – Understanding Remittance Advice

*For providers seeking information on reading and understanding remittance advice documents*

# Definitions

## Adjustments

Reprocessing of a paid claim

## Claim Specific Recoupments

A financial item that is the result of a request to reverse payment of a claim with no subsequent processing. It is deducted from the next Medicaid payment.

## Refund

A financial item that is the result of a provider sending a check to Hewlett Packard Enterprise (HPE). Refund checks need to be claim specific. Claim related refunds result in the reversal of payment of a specific claim.

# Adjustments

The Adjustment Request Form is used to request adjustments of paid or partially paid claims

Denied claims or denied details cannot be adjusted

Copy the **Internal Control Number (ICN)** of the claim in question, and **Medicaid ID number** directly from the Remittance Advice

Enter exactly what you want to adjust on the claim form:  
*Example: Change the units from 1 to 2; increase the billed amount from \$50.00 to \$100.00*

The Remittance Advice (Settlement) page corresponding to the claim being Adjusted **must be included** with the Adjustment Request form.

# Adjustment Request Form Sample



Rhode Island Executive Office of Health and Human Services – Medicaid Program

## Claim Adjustment Request Form



ALL FIELDS ARE MANDATORY - the claim adjustment request form will be returned to the provider if incomplete. Claim type must be same for all.

Provider Name		Mailing Address			City	State	Zip
ICN (15 characters)		Detail Number*	Recipient Medicaid ID	From DOS*	To DOS*	Adjustment Reason Code	Claim Field Update/Change
123456789123456		3	1000555555	01/01/2016	01/01/2016	054	Change TPL payment amount to \$100.00
						Select	
						Select	
						Select	

\*\*Please enter "ALL" if request is to adjust entire claim.

### Applicable Adjustment Reason Codes

Reason Code	Financial Reason Code Description	Reason Code	Financial Reason Code Description
020	Wrong dates of service	054**	Provider wrong TPL payment**
021	Wrong patient status	065	Drug unit dose adjustment
026	Adjusted wrong tooth number/surface	067	Change in recipient eligibility
029	Incorrect Medicare paid amount, co-ins/eductible	068	Recipient has Medicare coverage
050	Provider Wrong Proc/Drug code	069	Recipient has verified other insurance
051	Provider wrong procedure modifier	070	Provider Change in Ownership
052	Provider wrong units of service	087	Adjust Wrong Units and Billed Amount
053	Provider wrong submitted charge	160	Retro rate, liability change

\*Adjustments for dates-of-service >365 days are not allowed when a new claim will be submitted for increased reimbursement without a primary payer EOB dated within 90 days.

\*\*Must attach primary payer explanation of benefits for Adjustment Reason Code 054

Print, sign and mail to:

RI MEDICAID PROGRAM • Hewlett Packard Enterprise • P.O. BOX 2010 • WARWICK, RI 02887-2010

Requestor (Print Name):	Title:
Provider/Authorized Agent Signature:	HPE Use Only
Date:	HPE Examiner:
	Date:

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\*Claims can be replaced electronically if submitted within one calendar year. This process makes corrections and resubmissions quick and easy. Please contact your provider representative for more information.\*

- Used to make changes on paid claims only
- A copy of the RA is required for processing
- All fields required to be completed for processing

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# Adjustment Request Form– Common Errors

- No signature – copied signature
- Faxed form
- Using the performing provider NPI instead of the billing NPI
- Using the wrong form for the transaction
- The detail number indicated doesn't match the dates of service indicated
- Incorrect ICNs/digits missing
- Provider asks Medicaid to change the OI payment and attached the OI EOB – but does not write the amount on the adjustment form. OI payments are keyed from the adjustment form not the EOB.

# RA – Paid Adjusted Claims Example

PROV: 900000X

RHODE ISLAND MEDICAL ASSISTANCE PROGRAM REMITTANCE ADVICE  
 LTC AND PROFESSIONAL  
 RA DATE: 04/04/2008

RA NUM: 00

PAGE NUM: 6

RECIPIENT NAME MID ICN HVER PT ACCT/RX BILLED AMT ALLOWED AMT OI AMT LIAB AMT COPAY AMT PAID AMT  
 HEADER MESSAGES  
 DNUM DVER FDOS TDOS PROC + MODS QTY BLD  
 DETAIL MESSAGES  
 ADJUSTED CLAIMS

PERRY HA 03H999999 481997HA3011189 01 03850  
 01 00 12/16/07 12/16/07 B9999 1.00 115.00 99.00 0.00 0.00 0.00 99.00

ORIGINAL CLAIM TOTALS: 115.00 99.00 0.00 0.00 0.00 99.00

RECOUPMENT TO ORIGINAL CLAIM - PAID DATE: 08/01/97 PAID AMOUNT: 99.00

PERRY HA 038H99999 481997HA3011189 02 03850  
 01 01 12/16/07 12/16/07 B9999 2.00 230.00 200.00 0.00 0.00 0.00 200.00

ADJUSTMENT CLAIM TOTALS: 230.00 200.00 0.00 0.00 0.00 200.00

ADJUSTMENT REASON: Retro Rate Adjustment  
 NET ADJUSTMENT AMOUNT: \$101.00  
 ORIGINAL CLAIM PAID BEFORE ADJUSTMENT: \$99.00

ADJUSTMENT CLAIM TOTALS: 1 CLAIM(S) 230.00 200.00 0.00 0.00 0.00 200.00

\*\*\*\*\*  
 \* PAID CLAIM ACCOUNTS RECEIVABLE RELATED TO ORIGINAL PAID CLAIM AMOUNTS FOR THIS \*  
 \* FINANCIAL CYCLE: \*  
 \* 1 ORIGINAL CLAIM(S) PAID AMOUNT: 99.00 \*  
 \*\*\*\*\*

# RA – Denied Adjusted Claims Example

PROV: 900000X      RHODE ISLAND MEDICAL ASSISTANCE PROGRAM REMITTANCE ADVICE      RA NUM: 000023AB01  
 LTC AND PROFESSIONAL  
 RA DATE: 04/04/2008      PAGE NUM: 7

RECIPIENT NAME MID      ICN      HVER PT ACCT/RX BILLED AMT      ALLOWED AMT      OI AMT      LIAB AMT      COPAY AMT      PAID AMT  
 HEADER MESSAGES  
 DNUM DVER FDOS TDOS PROC + MODS      QTY BLD  
 DETAIL MESSAGES  
 DENIED ADJUSTED CLAIMS

SIMAS IN      569888888      481996152ABC02 00 0123

01 00	12/31/2007	12/31/2007	A0000	150.00	361.50	252.00	0.00	0.00	0.00	252.00
02 00	12/31/2008	12/31/2008	A9999	150.00	1,258.50	1,163.98	0.00	0.00	0.00	1,163.98
ORIGINAL CLAIM TOTALS:					1,620.00	1,415.98	0.00	0.00	0.00	1,415.98

RECOUPMENT TO ORIGINAL CLAIM - PAID DATE: 06/20/96 PAID AMOUNT: 1,415.98

SIMAS IN      569888888      481996152ABC02 01 0123

01 00	12/31/2007	12/31/2007	A0000	100.00	250.00	0.00	0.00	0.00	0.00	0.00
	799/801									
02 00	12/31/2008	12/31/2008	A9999	150.00	1,258.50	0.00	0.00	0.00	0.00	0.00
	799/801									
ADJUSTMENT CLAIM TOTALS:					1,508.50	0.00	0.00	0.00	0.00	0.00

ADJUSTMENT REASON: Retro Rate Adjustment      NET ADJUSTMENT AMOUNT: \$1,415.98-  
 ORIGINAL CLAIM PAID BEFORE ADJUSTMENT: \$1,415.98

ADJUSTMENT CLAIM TOTALS:      1 CLAIM(S)      1,508.50      0.00      0.00      0.00      0.00      0.00

\*\*\*\*\*  
 \* PAID CLAIM ACCOUNTS RECEIVABLE RELATED TO ORIGINAL PAID CLAIM AMOUNTS FOR THIS \*  
 \* FINANCIAL CYCLE: \*  
 \* 1 ORIGINAL CLAIM(S)      PAID AMOUNT: 1,415.98 \*  
 \*\*\*\*\*

\*\*\*\*\*  
 \*TOTAL PAID AND DENIED CLAIM ACCOUNTS RECEIVABLE RELATED TO ORIGINAL PAID CLAIM \*  
 \*AMOUNTS FOR THIS FINANCIAL CYCLE: \*  
 \* 1 ORIGINAL CLAIM(S):      PAID AMOUNT: 1,415.98 \*  
 \*\*\*\*\*

# RA – Suspended Adjusted Claims Example

SUSPENDED ADJUSTMENTS										
JAMES JE 55555555 48200701105ABCD 00 54321										
02 01	12/05/07	12/05/07	E0250 RR	1.00	80.00	0.00	0.00	0.00	0.00	0.00
	011/108									
ADJUSTMENT CLAIM TOTALS:					80.00	0.00	0.00	0.00	0.00	0.00
TOTALS FOR CLAIM TYPE: PROFESSIONAL				1 CLAIM(S)	80.00	0.00	0.00	0.00	0.00	0.00
SUSPENDED ADJUSTMENT TOTALS:				1 CLAIM(S)	80.00	0.00	0.00	0.00	0.00	0.00

# Recoupments



Rhode Island Executive Office of Health and Human Services  
Medicaid Program



## Claim Recoupment Request

ALL FIELDS ARE MANDATORY - the claim recoupment request form will be returned to the provider if incomplete. Claim type must be same for all.

Provider Name				Provider NPI	
Mailing Address	No./Street	City		State	Zip
ICN (15 characters)	Detail Number(s)*	Recipient Medicaid ID	From DOS**	To DOS**	Recoupment Reason Code
123456789123456	3	1000555555	01/01/2016	01/01/2016	054
					Select

\*Please enter "ALL" if the request is to recoup the ENTIRE claim.

### Applicable Recoupment Reason Codes

Reason Code	Reason Code Description	Reason Code	Reason Code Description
019	Client covered through Rite Care/Share	052	Provider wrong units of service
020	Wrong dates of service	053	Provider wrong submitted charge
021	Wrong patient status	054	Provider wrong TPL payment
026	Adjusted wrong tooth number/surface	055	Provider duplicate payment
027	Recoup script cancelled/refused, not picked up	066	Client did not receive service
029	Incorrect Medicare paid amount, co-ins/deductible	067	Change in recipient eligibility
048	Provider wrong provider number	068	Recipient has Medicare coverage
049	Provider wrong recipient number	069	Recipient has verified other insurance
050	Provider Wrong Proc/Drug code	118	Auto insurance paid claim
051	Provider wrong procedure modifier	121	Claim paid by attorney

\*\*Recoupments for dates-of-service >365 days are not allowed when a new claim will be submitted for increased reimbursement without a primary payer EOS dated within 90 days.

Print, sign and mail to:

RI MEDICAID PROGRAM • HEWLETT PACKARD ENTERPRISE • P.O. BOX 2010 • WARWICK, RI 02887-2010

Requestor (Print Name):	Title:
Provider/Authorized Agent Signature:	HPE Use Only
Date:	HPE Examiner:
	Date:

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\*Claims can be voided electronically if submitted within one calendar year. This process makes corrections and resubmissions quick and easy. Please contact your provider representative for more information.\*

There are occasions when it is necessary for the provider to recoup the full amount paid by EOHHS.

The Claim Recoupment Request Form can be used to recoup an overpayment by EOHHS.

Recoupments are deducted from the next Medicaid payment.

# Refunds



Rhode Island Executive Office of Health and Human Services  
Medicaid Program  
Refund Request

ALL FIELDS ARE MANDATORY – if incomplete, the refund request form will be returned to the provider with a letter requesting additional information. Please note that all checks are deposited upon receipt.

Provider Name \_\_\_\_\_ Contact Name \_\_\_\_\_  
 Provider NPI \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

#	Recipient Name	MID #	ICN #	Detail # (If Applicable)	DOS	RA Date	Refund Amount	Refund Reason
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								



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Refunds can be made by sending in a check made payable to the State of Rhode Island

A copy of the Remittance Advice (RA) containing the appropriate claim(s) must be included with the check

On the RA, circle or highlight the claim(s) corresponding to the refund and indicate the reason for the refund

# Electronic Replacement/Void Claims (PES Users)

## For Dental, Professional, and Waiver Claims

### Replacements

Previously paid claims can be adjusted by using the Replacement Claim transaction.

On HDR 1, select Claim Frequency Code **7** and enter ICN of original claim  
Key the entire claim as it should have been keyed, making all corrections.

### Voids

Previously paid claims can be recouped by using the Void Claim transaction.

Copy entire original claim.  
On HDR 1, select Claim Frequency Code **8** and enter ICN of original claim.

This voids entire claim. If you only want to remove one line – use replacement.

Save the claim. The next time you transmit, this replacement or void will be transmitted and processed.

# Electronic Replacement/Void Claims (PES users)

## For Institutional Claims

### Replacements

Previously paid claims can be adjusted by using the Replacement Claim transaction.

On HDR 1, change the third digit of the Type of Bill to **7** for Replacement, and enter the ICN of the original claim. Key the entire claim as it should have been keyed, making all corrections.

### Voids

Previously paid claims can be recouped by using the Void Claim transaction.

Copy entire original claim.  
On HDR 1, change the third digit of the Type of Bill to **8** for Void and enter the ICN of original claim.

This voids entire claim. If you only want to remove one line - use replacement.

Save the claim. The next time you transmit, this replacement or void will be transmitted and processed.

# RA – Electronic Replacement

PROV: 900000X		RHODE ISLAND MEDICAL ASSI		Billed Amount	GRAM R	Allowed Amount	ADVICE	RA NUM: 000023A		Paid Amount
		LTC AND PROFESSIONAL								
		RA DATE: 04/04/2008			PAGE NUM:					
RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
HEADER MESSAGES										
DNUM	DVER	FDOS	TDOS	PROC + MODS	QTY	BLD				
DETAIL MESSAGES										
PAID CLAIMS										
DOE	JO 038A88888	102013235999999	00	23464				1		
02 00	07/02/07	07/02/07	E1345	1.00	100.00	100.00	0.00	0.00	0.00	100.00
CLAIM TOTALS:					100.00	100.00	0.00	0.00	0.00	100.00
SMITH	JA 0366B9999	482013235999999	00	12345				7		
01 00	08/24/07	08/24/07	9921X	1.00	50.00	50.00	0.00	0.00	0.00	50.00
CLAIM TOTALS:					50.00	50.00	0.00	0.00	0.00	50.00
TOTALS FOR CLAIM TYPE: PROFESSIONAL 2 CLAIM(S)					150.00	150.00	0.00	0.00	0.00	150.00

# RA – Financial Items Example

PROV: 900000X  
RA NUM: 000023AB01

RHODE ISLAND MEDICAL ASSISTANCE PROGRAM REMITTANCE ADVICE

LTC AND PROFESSIONAL  
RA DATE: 04/08/2008

PAGE NUM: 8

## FINANCIAL ITEMS

CCN	A/L NUM	MID	ICN	HVER	DNUM	DVER	TXN DATE	ORIG AMT	TXN AMT	BAL AMT	RSN CODE	K
123456789012345	552008217000000	215000897	422008020012854	00	00	00	12/05/07	13.25	13.25	13.25	055	
213456789012354	552000001000009	569888888	422008152ABC402	00	01	00	09/05/07	1,514.98	1,514.98	1,514.98	149	
		03H999999	421997HA3011189	01	01	00						
502000000034999	552008217000000						08/05/07	13.25	13.25	0.00	103	
502000000001155	552000001000009						09/05/07	1,514.98	152.75	1,362.23	103	

\*\*\* FINANCIAL REASON CODES \*\*\*

- 055 PROVIDER DUPLICATE PAYMENT
- 103 RECOUPMENT APPLIED TO ACCOUNT RECEIVABLE
- 149 SYSTEM GENERATED MASS ADJUSTMENT

# RA – Headings on Financial Items Section

<b>CCN</b>	Cash Control Number – Internal tracking number for the set-up of an accounts receivable from an adjustment, recoupment or voided transaction.
<b>A/L NUM</b>	Account Ledger Number – Tracking number that follows the adjustment, recoupment or voided transaction through to completion, when the balance is \$0.
<b>MID</b>	Medicaid Identification Number
<b>ICN</b>	Internal Control Number – 15 digit number assigned to the claim when received by RI Medicaid
<b>HVER</b>	Header Version – The version number of the claim at the claim header level
<b>DNUM</b>	Detail Number – The line item number of the claim

# RA – Headings on Financial Items Section

<b>DVER</b>	Detail Version – The version of the line item number
<b>TXN DATE</b>	Transaction Date – The date the adjustment, recoupment or void is being set up
<b>ORIG AMT</b>	Original Amount – The dollar amount of the original claim paid
<b>TXN AMT</b>	Transaction Amount – The dollar amount of the adjustment, recoupment of void being set up
<b>BAL AMT</b>	Balance Amount – The amount of the accounts receivable set up from the adjustment, recoupment or voided transaction
<b>RSN CODE</b>	Reason Code – The reason the financial transaction was performed



# Questions and Answers

*Thank you for viewing this presentation*