

## Section 8. Resolving Denied Claims

### Claim Adjustments

#### Resubmission of a Denied Claim

The **Medicaid Claim Adjustment Request Form** is used to adjust a previously paid claim or a denied claim. If your paid or denied claim was for one of the explanations of benefits (EOBs) listed at the end of this section, do **not** file as an adjustment; these claims can be refiled as new claims. If your EOB is not listed below, please use the **Medicaid Claim Adjustment Request Form** to process your claim. Do not use the **Medicaid Claim Adjustment Request Form** to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Use the **Medicaid Resolution Inquiry Form** if you have exceeded the filing time limit.

When submitting adjustment requests, always attach a copy of any Remittance and Status Report (RA) related to the adjustment as well as any medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment, but it is not required if the claim was filed electronically.

Within 30 days of filing a **Medicaid Claim Adjustment Request Form**, you will see the status of the claim listed on the RA as “pending.” If the status code does not appear as pending, verify that the recipient’s Medicaid identification (MID) number and the internal claim number (ICN) are complete and correct. If the MID number or internal control number (ICN) is incorrect, refile the adjustment request with the correct information.

#### Instructions for Completing the Medicaid Claim Adjustment Request Form

The instructions for completing the **Medicaid Claim Adjustment Request Form** are listed below. A copy of the **Medicaid Claim Adjustment Request Form** is on DMA’s website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

| Line                      | Instruction   |
|---------------------------|---|
| <b>Provider Number</b>    | Billing provider’s number   |
| <b>Provider Name</b>      | Name of billing provider  |
| <b>Recipient Name</b>     | Recipient’s name  |
| <b>Recipient ID</b>       | Recipient’s MID number  |
| <b>Claim Number</b>       | The ICN followed by the 5-character financial payer code as shown on the RA. Always reference the original ICN even if you have a subsequent denied adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number. |
| <b>Date of Service</b>    | Beginning and ending date of service covered on the original claim  |
| <b>Billed Amount</b>      | Amount billed on the original claim   |
| <b>Paid Amount</b>        | Amount paid on the original claim   |
| <b>RA Date</b>            | Date the original claim was paid  |
| <b>Type of Adjustment</b> | Reason for the adjustment (overpayment, full recoupment, etc.)  |

| <b>Changes or Corrections to be Made</b>      |  |
|---|--|
| <b>Line</b>                                   | <b>Instruction</b>   |
| <b>Units</b>                                  | Correct number of units  |
| <b>Dates of Service</b>                       | Correct date of service  |
| <b>Third Party Liability (TPL)</b>            | Indicate TPL amount on the adjustment form and include a copy of the TPL voucher showing payment.  |
| <b>Procedure/ Diagnosis Code</b>              | Indicate the combined procedure code or revenue code and the corrected billed amount.  |
| <b>Patient Liability</b>                      | <p>Include the latest <b>Patient Monthly Liability Form (DMA-5016)</b> pertaining to the date of service. Include all related RAs showing a liability amount applied to the claim.</p> <p>The adjustment request will be reviewed by DMA's Claims Analysis Unit. If your RA indicates an EOB 9607 adjustment being reviewed for a change in patient liability, do not refile or resubmit the adjustment; it will be processed for you.</p> |
| <b>Medicare Adjustment</b>                    | <p>Attach the original and the adjusted Medicare vouchers. Use the ICN for the previously paid claim for the claim referenced on the adjustment form. Indicate all related Medicare vouchers. If Medicare processing necessitates an adjustment payment on two separate claims, send both claim copies and both Medicare vouchers. Use the ICN for the denied duplicate claim for the claim references on the adjustment form.</p>         |
| <b>Billed Amounts</b>                         | Show the total billed amount on the adjustment request form. Do not use the difference between the original claim and the adjusted claim as the billed amount.   |
| <b>Further Medical Review</b>                 | Submit only the medical records, operative notes, anesthesia records, etc., that may affect the claims payment. These records are used by medical staff to determine whether to reimburse the providers or deny the adjustment as paid correctly.  |
| <b>Other Duplicate Denials</b>                | When filing an adjustment for a duplicate denial, attach medical records or radiology reports for the dates of service in question. Do not submit the adjustment form or medical records with front and back copies. All records and forms are scanned on the front side only.   |
| <b>Specific Reason for Adjustment Request</b> | Reason for the adjustment. If the adjustment is a result of procedures' not being combined, indicate the codes that are being combined. If the adjustment is necessitated by incorrect units, indicate the total number of correct units as it should have appeared on the original claim along with the corrected billed amount and the correct date of service.  |
| <b>Signature of Sender</b>                    | Name of the person filling out the form  |
| <b>Date</b>                                   | Date the adjustment request is submitted or mailed   |
| <b>Phone number</b>                           | Area code and telephone number for the person filling out the form.  |

## Tips for Filing Adjustments

The following tips will assist in completing the adjustment form

- Complete only one adjustment request form per claim; a separate adjustment request form for each line item on a single claim is not necessary.
- Reference only one ICN per adjustment request form.
- If requesting a review of a previously denied adjustment, reference the original ICN and resubmit with all supporting documentation related to the adjustment. Do not reference the ICN for the denied adjustment.
- Include a copy of the appropriate RA with each adjustment request. If multiple RAs were involved in the claim payment process, include copies of each RA.
- Include a copy of the claim that is referenced on the adjustment request.  
**Note:** This is not required for electronically submitted claims.
- When the adjustment request involves a corrected or revised claim, send both the original and revised claim. Do not obliterate previously paid details on the claim.
- Include pertinent information on a separate sheet of paper. Do not write information on the back of the adjustment form, RAs, etc.
- Ensure that all of the information submitted with the adjustment request is legible.
- Send only the medical records that pertain to the services rendered. If it is necessary to send records with other information included, identify the portion of the record that is significant to the adjustment request.
- Only the claim that pertains to the payment or denial in question should be submitted with the adjustment request. Do not submit any other claims with the adjustment request. Claims for service dates that have not been submitted should be filed on a new day claim, including late charges for codes not previously filed.
- When submitting an adjustment to Medicaid due to a Medicare-adjusted voucher, attach both the original voucher and the adjusted Medicare voucher. Reference the ICN of the original voucher.
- If requesting a review of a previous partial payment or a partial recoup adjustment, reference the ICN for the adjustment and resubmit with all supporting documentation related to the adjustment.
- Adjustments equal to or less than \$1.00 will be denied.

The most common mistakes that are made when filing adjustments are these:

- Incomplete or invalid MID information or ICNs
- Multiple ICNs on the same form
- Unspecified or too-general reason for the adjustment request
- Missing copy of the RA related to the request
- Missing reference to the original ICN, or use of a denied adjustment ICN
- A partial payment or partial recoupment number is not referenced as the original ICN
- Filing the adjustment after the 18-month time limit  
**Note:** If an adjustment is not filed until the 17th month from the date of service, the original claim may no longer be available in the system for adjustment. Submit adjustments as soon as possible so they can be processed within the 18-month time limit.
- Missing required documentation (Medicare vouchers, medical records, operative records, etc).
- Referencing the NPI on the adjustment request

**Note:** This form requests the MPN in the blank specified for Provider Number.

## RA Requirements for Paper Adjustments

- Paper adjustment processing procedures require that providers attach a copy of all paper Medicaid RA pages related to the referenced claim.
- A provider-generated RA, or a copy of the electronic RA (835 transaction) is not an acceptable substitute for the paper copy mailed to providers by EDS. Provider-generated RAs have varied formats and do not include all information necessary for manual adjustment processing.
- Paper adjustments that do not include the required RA will be denied with EOB 812, “Adjustment denied. Please refile with all related RA’s, including original processing.” Providers receiving this denial should resubmit a copy of their adjustment with the requested RA.
- If you do not have a copy of the paper RA, contact EDS Provider Services to request a replacement. (There is a per-page charge for RA requests that are more than 10 checkwrites old. RA reprints for the last 10 checkwrites are provided at no charge. Refer to **How to Request a Duplicate Remittance and Status Report** in **Section 9, Remittance and Status Report**, for additional information.)

## Submitting an Adjustment Electronically

With the implementation of standard claims transactions to comply with the Health Insurance Portability and Accountability Act (HIPAA), adjustments may be filed electronically. There are two separate actions that may be filed:

1. Void—in order to file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-04) on the 837 electronic claim transaction. The ICN for the original claim to be voided must also be provided. When processed, the claim associated with the original ICN will be recouped from the patient’s record and the payment will be recouped from the provider’s RA.
2. Replacement—a replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB04) on the electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient’s record and shown as a recoupment on the RA when the replacement claim processes and pays without error. If the replacement claim is denied, the entire replacement process will be denied, including the recoupment.

N.C. Medicaid will continue to accept and process paper adjustments. Although adjustments may be filed electronically, providers are advised to file adjustments on paper when paper documentation is required.

## EOB Denials That Do Not Require Filing an Adjustment

In most situations, if one of the following EOBs is received, providers should refile the claim with correct information. If adjustments are submitted for the EOBs below, the claim will be denied for EOB 998, which states, “Claim does not require adjustment processing, resubmit claim with corrections as a new day claim,” or EOB 9600, which states, “Adjustment denied; if claim was with adjustment it has been resubmitted. The EOB this claim previously denied for does not require adjusting.”

In the future, resubmit a new or corrected claim in lieu of sending an adjustment request. Do not automatically file an adjustment if a claim receives an EOB that is not included on this list; that may not be how that specific claim situation should be resolved. Please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 if there are any questions on how to resolve a specific denial (last revised August 2009).

|      |      |      |      |      |      |      |      |      |      |
|------|------|------|------|------|------|------|------|------|------|
| 0002 | 0003 | 0004 | 0005 | 0007 | 0009 | 0011 | 0013 | 0017 | 0019 |
| 0023 | 0024 | 0025 | 0026 | 0027 | 0029 | 0033 | 0034 | 0035 | 0036 |
| 0038 | 0039 | 0040 | 0041 | 0042 | 0046 | 0047 | 0050 | 0051 | 0058 |
| 0062 | 0063 | 0065 | 0067 | 0068 | 0069 | 0074 | 0075 | 0076 | 0077 |
| 0078 | 0079 | 0080 | 0082 | 0084 | 0085 | 0089 | 0090 | 0093 | 0094 |
| 0095 | 0100 | 0101 | 0102 | 0103 | 0104 | 0105 | 0106 | 0108 | 0110 |
| 0111 | 0112 | 0113 | 0114 | 0115 | 0118 | 0120 | 0121 | 0122 | 0126 |
| 0128 | 0129 | 0131 | 0132 | 0133 | 0134 | 0135 | 0138 | 0141 | 0143 |
| 0144 | 0145 | 0149 | 0151 | 0153 | 0154 | 0155 | 0156 | 0157 | 0158 |
| 0159 | 0160 | 0162 | 0163 | 0164 | 0165 | 0166 | 0167 | 0170 | 0171 |
| 0172 | 0174 | 0175 | 0176 | 0177 | 0179 | 0181 | 0182 | 0183 | 0185 |
| 0186 | 0187 | 0188 | 0189 | 0191 | 0194 | 0195 | 0196 | 0197 | 0198 |
| 0199 | 0200 | 0201 | 0202 | 0203 | 0204 | 0205 | 0206 | 0207 | 0208 |
| 0213 | 0215 | 0217 | 0219 | 0220 | 0221 | 0222 | 0226 | 0227 | 0235 |
| 0236 | 0237 | 0240 | 0241 | 0242 | 0244 | 0245 | 0246 | 0247 | 0249 |
| 0250 | 0251 | 0253 | 0255 | 0256 | 0257 | 0258 | 0270 | 0279 | 0282 |
| 0283 | 0284 | 0286 | 0289 | 0290 | 0291 | 0292 | 0293 | 0294 | 0295 |
| 0296 | 0297 | 0298 | 0319 | 0325 | 0326 | 0327 | 0356 | 0363 | 0364 |
| 0394 | 0398 | 0424 | 0425 | 0426 | 0427 | 0428 | 0430 | 0435 | 0438 |
| 0439 | 0452 | 0462 | 0465 | 0505 | 0511 | 0513 | 0516 | 0523 | 0529 |
| 0536 | 0537 | 0548 | 0553 | 0556 | 0557 | 0558 | 0559 | 0560 | 0569 |
| 0572 | 0574 | 0575 | 0576 | 0577 | 0578 | 0579 | 0580 | 0581 | 0584 |
| 0585 | 0586 | 0587 | 0588 | 0589 | 0590 | 0593 | 0604 | 0607 | 0609 |
| 0611 | 0612 | 0616 | 0620 | 0621 | 0622 | 0641 | 0642 | 0661 | 0662 |
| 0663 | 0665 | 0666 | 0668 | 0669 | 0670 | 0671 | 0672 | 0673 | 0674 |
| 0675 | 0676 | 0677 | 0679 | 0680 | 0681 | 0682 | 0683 | 0685 | 0688 |
| 0689 | 0690 | 0691 | 0698 | 0732 | 0734 | 0735 | 0749 | 0755 | 0760 |
| 0777 | 0797 | 0804 | 0805 | 0814 | 0817 | 0819 | 0820 | 0822 | 0823 |
| 0824 | 0825 | 0860 | 0863 | 0864 | 0865 | 0866 | 0867 | 0868 | 0869 |
| 0875 | 0888 | 0889 | 0898 | 0900 | 0905 | 0908 | 0909 | 0910 | 0911 |
| 0912 | 0913 | 0916 | 0917 | 0918 | 0919 | 0920 | 0922 | 0925 | 0926 |
| 0929 | 0931 | 0932 | 0933 | 0934 | 0936 | 0940 | 0941 | 0942 | 0943 |
| 0944 | 0945 | 0946 | 0947 | 0948 | 0949 | 0950 | 0952 | 0960 | 0967 |
| 0968 | 0969 | 0970 | 0972 | 0974 | 0986 | 0987 | 0988 | 0989 | 0990 |
| 0991 | 0992 | 0995 | 0997 | 0998 | 1001 | 1003 | 1008 | 1022 | 1023 |
| 1035 | 1036 | 1037 | 1038 | 1043 | 1045 | 1046 | 1047 | 1048 | 1049 |
| 1050 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1078 |
| 1079 | 1084 | 1086 | 1087 | 1091 | 1092 | 1152 | 1154 | 1156 | 1170 |
| 1175 | 1177 | 1178 | 1181 | 1183 | 1184 | 1186 | 1197 | 1204 | 1232 |
| 1233 | 1275 | 1278 | 1307 | 1324 | 1350 | 1351 | 1355 | 1380 | 1381 |
| 1382 | 1396 | 1399 | 1400 | 1404 | 1422 | 1442 | 1443 | 1502 | 1506 |
| 1513 | 1866 | 1868 | 1873 | 1944 | 1949 | 1956 | 1999 | 2024 | 2027 |
| 2107 | 2149 | 2207 | 2235 | 2236 | 2237 | 2238 | 2911 | 2912 | 2913 |
| 2914 | 2915 | 2916 | 2917 | 2918 | 2919 | 2920 | 2921 | 2922 | 2923 |
| 2924 | 2925 | 2926 | 2927 | 2928 | 2929 | 2930 | 2931 | 2944 | 3001 |
| 3002 | 3003 | 3101 | 3102 | 3105 | 3106 | 3107 | 3208 | 3209 | 5001 |
| 5002 | 5201 | 5206 | 5216 | 5221 | 5222 | 5223 | 5224 | 5225 | 5226 |
| 5227 | 5228 | 5229 | 5230 | 6703 | 6704 | 6705 | 6707 | 6708 | 7700 |
| 7701 | 7702 | 7703 | 7705 | 7706 | 7707 | 7708 | 7709 | 7712 | 7717 |

|      |      |      |      |      |      |      |      |      |      |
|------|------|------|------|------|------|------|------|------|------|
| 7733 | 7734 | 7735 | 7736 | 7737 | 7738 | 7740 | 7741 | 7788 | 7794 |
| 7900 | 7901 | 7904 | 7905 | 7906 | 7907 | 7908 | 7909 | 7910 | 7911 |
| 7912 | 7913 | 7914 | 7915 | 7916 | 7917 | 7918 | 7919 | 7920 | 7921 |
| 7922 | 7923 | 7924 | 7925 | 7926 | 7927 | 7928 | 7929 | 7930 | 7931 |
| 7932 | 7933 | 7934 | 7935 | 7936 | 7937 | 7938 | 7939 | 7940 | 7941 |
| 7942 | 7943 | 7944 | 7945 | 7946 | 7947 | 7948 | 7949 | 7950 | 7951 |
| 7952 | 7953 | 7954 | 7955 | 7956 | 7957 | 7958 | 7959 | 7960 | 7961 |
| 7962 | 7963 | 7964 | 7965 | 7966 | 7967 | 7968 | 7969 | 7970 | 7971 |
| 7972 | 7973 | 7974 | 7975 | 7976 | 7977 | 7978 | 7979 | 7980 | 7981 |
| 7982 | 7983 | 7984 | 7985 | 7989 | 7990 | 7991 | 7992 | 7993 | 7994 |
| 7995 | 7996 | 7997 | 7998 | 7999 | 8174 | 8175 | 8326 | 8327 | 8400 |
| 8401 | 8901 | 8902 | 8903 | 8904 | 8905 | 8906 | 8907 | 8908 | 8909 |
| 8989 | 8990 | 8991 | 8992 | 8993 | 8994 | 8995 | 8996 | 8997 | 8998 |
| 8999 | 9011 | 9012 | 9013 | 9014 | 9015 | 9016 | 9017 | 9018 | 9019 |
| 9020 | 9021 | 9036 | 9054 | 9101 | 9102 | 9103 | 9104 | 9105 | 9106 |
| 9174 | 9175 | 9180 | 9198 | 9200 | 9201 | 9202 | 9203 | 9204 | 9205 |
| 9206 | 9207 | 9208 | 9209 | 9210 | 9211 | 9212 | 9213 | 9214 | 9215 |
| 9216 | 9217 | 9218 | 9219 | 9220 | 9221 | 9222 | 9223 | 9224 | 9225 |
| 9226 | 9227 | 9228 | 9229 | 9230 | 9231 | 9232 | 9233 | 9234 | 9235 |
| 9236 | 9237 | 9238 | 9239 | 9240 | 9241 | 9242 | 9243 | 9244 | 9245 |
| 9246 | 9247 | 9248 | 9249 | 9250 | 9251 | 9252 | 9253 | 9254 | 9256 |
| 9257 | 9258 | 9259 | 9260 | 9261 | 9268 | 9269 | 9272 | 9273 | 9274 |
| 9275 | 9291 | 9295 | 9496 | 9497 | 9498 | 9499 | 9500 | 9501 | 9502 |
| 9503 | 9504 | 9505 | 9506 | 9600 | 9611 | 9614 | 9615 | 9625 | 9630 |
| 9631 | 9633 | 9642 | 9684 | 9801 | 9804 | 9806 | 9807 | 9898 | 9899 |
| 9992 | 9919 | 9993 | 9994 |      |      |      |      |      |      |

**Note:** This list is not all inclusive.

## Pharmacy Claim Adjustments

A **Pharmacy Adjustment Request Form** is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the **Pharmacy Adjustment Request Form** to do the following:

- Credit Medicaid for a billed and paid prescription that was never dispensed
- Credit Medicaid for a billed and paid prescription for unit-dose drugs that were unused
- Correct National Drug Code (NDC), quantity, days supply, date of service, billed amount, Rx number, or third-party payment

## Instructions for Completing the Pharmacy Adjustment Request Form

The instructions for completing the **Pharmacy Adjustment Request Form** are shown below. A copy of the Pharmacy Request form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> (under Outpatient Pharmacy Providers).

| Line                                     | Instruction  |
|--|--|
| <b>Recipient Medicaid Number</b>         | Enter the recipient's MID number as it appears on the MID card.  |
| <b>Recipient Name</b>                    | Enter the recipient's name exactly as it appears on the MID card.  |
| <b>Pharmacy Name and Provider Number</b> | Enter the name of the pharmacy and the pharmacy's Medicaid provider number.  |
| <b>Rx Number</b>                         | Enter the prescription number assigned by the pharmacy to the prescription on claim to be adjusted.  |
| <b>Drug Name</b>                         | Enter the name of the drug dispensed, including the strength and the dosage form (abbreviated).  |
| <b>NDC</b>                               | Enter the 11-digit NDC for the prescription.   |
| <b>Quantity</b>                          | Enter the original quantity to be billed, using up to five digits.   |
| <b>Billed Amount</b>                     | Enter the original total to be billed for the prescription claim.  |
| <b>Date Filled</b>                       | Enter the original date the prescription was filled, using the MM/DD/YY format.  |
| <b>Claim Number</b>                      | Enter the ICN of the claim that is submitted to be adjusted.   |
| <b>Denial EOB</b>                        | Do not enter information in this block unless the claim was denied with EOB 0985, "Exceeding Prescription Limitation."   |
| <b>Insurance Paid</b>                    | Indicate a correction of omission of Other Payer Amount by placing an "X" in this box. Indicate in the "Adjustment Reason" block that the adjustment request is for an omission of Other Payer Amount. Attach appropriate documentation of the other payer amount to the adjustment request. |
| <b>Adjustment Reason</b>                 | State why a correction is needed.  |
| <b>Paid Amount</b>                       | Enter the amount of the original Medicaid payment for the claim identified by the ICN listed in the "Claim Number" block.  |

## Resolution Inquiries

The **Medicaid Resolution Inquiry Form** is used to submit claims for

- Time limit overrides
- Medicare overrides
- Third-party overrides
- Medicare HMO (Part C) CMS 1500 claims (see **Section 5, Submitting Claims to Medicaid**)

When submitting inquiry requests, always attach the claim and a copy of any paper RAs related to the inquiry request, as well as any other information related to the claim. (Provider-generated RAs or electronic RAs are not acceptable.) Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, attach only single-sided documents to the inquiry request. **Do not attach double-sided documents to the inquiry request.** A copy of the **Medicaid Resolution Inquiry Form** is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

## Time Limit Overrides

All Medicaid claims, except hospital inpatient and nursing facility claims, must be received by EDS within 365 days of the date of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the RA date to refile a claim.

If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted on paper or electronically as a new day claim. The new day claim must have an exact match of recipient MID number, provider number, from date of service, and total billed.

Claims that do not have an exact match to the original claim in the system will be denied for one of the following EOBs:

- 0018** Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.
- 8918** Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing—a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Because DMA and EDS must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include

- Dated correspondence from DMA or EDS about the specific claim received that is within 365 days of the date of service
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial
- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, you have **180** days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. You must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the Third-Party or Medicare EOB in order to request a time limit override.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Resolution Inquiry form and mail to the address indicated on the inquiry form.

## Instructions for Completing the Medicaid Resolution Inquiry Form

The instructions for completing the **Medicaid Resolution Inquiry Form** are shown below. A copy of the Medicaid Resolution Inquiry form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

| Line                               | Instruction  |
|------------------------------------|--|
| <b>Provider Number</b>             | Enter the billing provider's number.   |
| <b>Provider Name and Address</b>   | Enter the name and address of the billing provider.  |
| <b>Recipient Name</b>              | Enter the recipient's name exactly as it appears on the MID card.  |
| <b>Recipient ID</b>                | Enter the recipient's MID number as it appears on the MID card.  |
| <b>Date of Service</b>             | Enter the beginning and the ending date of service.  |
| <b>Claim Number</b>                | If the claim was previously processed, enter the ICN followed by the 5-character financial payer code as indicated on the RA. If this is the first submission, this information is not required. |
| <b>Billed Amount</b>               | Enter the amount billed on the claim.  |
| <b>Paid Amount</b>                 | If applicable, enter the amount paid on the original claim.  |
| <b>RA Date</b>                     | If applicable, enter the date the original claim was paid.   |
| <b>Specific Reason for Inquiry</b> | Indicate the reason for the inquiry (time limit override, TPL override, Medicare override, etc.). Identify attachments RAs, medical records, TPL or Medicare vouchers, etc.).                    |
| <b>Signature of Sender</b>         | Indicate the name of the person filling out the form.  |
| <b>Date</b>                        | Indicate the date the adjustment request is submitted or mailed.   |
| <b>Phone number</b>                | Indicate the area code and telephone number for the person filling out the form.   |

## Eligibility Denials

If claims are denied for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

### Step 1—Check for Errors on the Claim

Compare the recipient's eligibility information to the information entered on the claim.

If the information on the claim and the recipient's eligibility information do not match, correct the claim and resubmit on paper or electronically as a new day claim.

- If the claim is over the 365-day claim filing time limit, request a time limit override by submitting the claim and a completed **Medicaid Resolution Inquiry form** (<http://www.ncdhhs.gov/dma/provider/forms.htm>). Include a copy of the Remittance and Status Report (RA) or other documentation of timely filing.

- If the claim was originally received and processed within the 365-day claim filing time limit, resubmit the claim on paper or electronically as a new day claim, ensuring that the recipient's MID number, provider number, "from" date of service, and total billed match the original claim exactly.

## Step 2—Check for Data Entry Errors

Compare the RA to the information entered on the claim.

If the RA indicates that the recipient's name, MID number, or date of service has been keyed incorrectly, correct the claim and resubmit on paper or electronically as a new day claim.

- If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override.
- If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.

## Step 3—When All Information Matches

Verify that the recipient's eligibility information has been updated in the state eligibility file by utilizing the NCECS/Recipient Eligibility Verification Web Tool or by calling the AVR system.

If the NCECS/Recipient Eligibility Verification Web Tool or the AVR system indicates that the recipient is ineligible, submit a **Medicaid Resolution Inquiry form** to DMA Claims Analysis. Include the recipient eligibility information, the claim, and the RA. Mail to

Division of Medical Assistance  
Claims Analysis  
2501 Mail Service Center  
Raleigh NC 27699-2501

The Claims Analysis unit will review and update the information in EIS and resubmit the claim.

**Do not mail eligibility denials to EDS, as this will delay the processing of your claim.**

For further information, refer to **Appendix F, Verifying Recipient Eligibility** and **Appendix A, Automated Voice Response System**.

## Explanation of Benefits (EOBs) for Eligibility Denials

| Article I.<br>EOB | Message   | Explanation  |
|-------------------|---|--|
| 10                | Diagnosis or service invalid for recipient's age. | Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis. |
| 11                | Recipient not eligible on service date.           | Follow the instructions outlined in Steps 1, 2, and 3 above.   |
| 12                | Diagnosis or service invalid for recipient sex.   | Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis. |

| <b>Article I.<br/>EOB</b> | <b>Message</b>  | <b>Explanation</b>  |
|---------------------------|---|---|
| 84                        | Recipient is partially ineligible for service dates. Resubmit a new claim billing for only eligible dates of service. | Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.  |
| 93                        | Patient deceased per state eligibility file.  | Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.   |
| 120                       | Recipient MID number missing. Enter MID and submit as a new claim.  | Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.  |
| 139                       | Services limited to presumptive eligibility.  | Verify that on the date of service the recipient was eligible for all prenatal services, as well as for services required for conditions that may complicate the pregnancy on the date of service. Send the claim, eligibility information and a copy of the RA to DMA Claims Analysis.   |
| 143                       | MID number not on state eligibility file.   | Follow instructions in Steps 1 and 2 above. Make corrections, if necessary, and resubmit to EDS as a new claim. The MID number may be obtained through the NCECS/Recipient Eligibility Verification Web Tool or AVR system by using the Social Security Number (SSN) and date of birth. If recipient's SSN is unknown, call DMA Claims Analysis to obtain the correct MID number. |
| 191                       | MID number does not match patient name.   | Verify the recipient's name and MID number. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid's records. Call EDS Provider Services (1-800-688-6696) to verify the patient's name. Correct and resubmit to EDS as a new claim.  |
| 292                       | Qualified Medicare Beneficiary—MQB recipient  | If services billed are covered by Medicare, file charges to Medicare first.<br><br>Attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the co-insurance and deductible in accordance with the Part B reimbursement schedule.  |
| 953                       | Individual has restricted coverage - Medicaid only pays the part B premium.   | Medicaid is limited to payment of Medicare Part B premiums only.  |

## Recoupments

### Automatic Recoupments

If previously paid claims would cause a current claim to be denied during the audit review, EDS will initiate an adjustment to recoup the previously paid charges. This procedure ensures proper payment for services rendered. The following list shows examples of automatic recoupments. The list is not all inclusive.

- A current claim is filed for dialysis treatment, which includes previously paid charges. EDS will initiate an adjustment to recoup the previous payments in order to pay the dialysis treatment code (i.e., lab, supplies, etc.).
- A hospital files an inpatient claim on the same date of service as an outpatient claim. EDS will recoup the outpatient charges to pay the inpatient claim.
- A physician submits a claim and is paid for lab services that were performed at an independent lab. The independent lab also files a claim, which is denied as a duplicate. EDS will initiate an adjustment to recoup the charges paid to the attending physician for the lab services and pay the claim submitted by the independent lab.
- The assistant surgeon's or anesthesiologist's claim is filed without the appropriate modifier and is paid as though it were the primary surgeon, subsequently causing the primary surgeon's claim to deny as a duplicate. When an adjustment request is received from the primary surgeon, EDS will initiate a recoupment of the incorrect payment from the assistant surgeon or the anesthesiologist in order to pay the surgeon. The assistant surgeon or anesthesiologist must then submit a corrected claim with the appropriate modifiers.

### Provider Refunds

Overpayments, third party reimbursements, and incorrect claim submissions may occur in the processing of Medicaid claims. If the provider is not aware of other insurance coverage or liabilities for the recipient until after the receipt of Medicaid payment, the provider must still file a claim with the health insurance company, then refund to Medicaid the lesser of the two amounts received.

For example:

|                                       |         |
|---------------------------------------|---------|
| Amount billed by provider to Medicaid | \$50.00 |
| Amount paid by Medicaid               | 40.00   |
| Amount paid by private insurance      | 45.00   |
| Amount to be reimbursed to Medicaid   | 40.00   |

**Note:** Although the refund process is available to send monies back to Medicaid, the preferred method is through the void or replacement electronic adjustments.

### Submitting Refunds with a Remittance and Status Report

When submitting a refund request using the RA, follow these instructions:

- Highlight the appropriate recipient name and MID number, claim information (ICN), and dollar amount of the refund to apply to that recipient.
- Ensure that the check amount and notations on the RA agree to the same total being refunded.
- Attach a copy of the RA to the check and submit.

- Refund checks must be payable to EDS – Refund. Mail the refund with the requested information to

EDS  
ATTN: Finance - REFUND  
P.O. Box 300011  
Raleigh NC 27622-3011

## Submitting Refunds with the Medicaid Provider Refund Form

If a copy of the RA is not available, providers are able to submit a refund request using the **Medicaid Provider Refund Form**. This form is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> (under Claims and Claim Adjustment forms).

When completing the **Medicaid Provider Refund Form**, follow these instructions:

- Enter the data electronically before printing the form to reduce questions from EDS when the check and form are received.
- Enter information for each claim by detail line. As entries are made into the form, the total refund amount will be automatically calculated.
- The sum of the entries **must** equal the amount of the refund check submitted with this form.
- Once the form entries are completed, compare the total amount on the refund check to the calculated total refund amount in cell L13 on the form. This will cross check the entries on the form with the intended refund amount.
- Print a copy of the completed **Medicaid Provider Refund Form** and submit.
- Refund checks must be payable to EDS – Refund. Mail the refund with the requested information to

EDS  
ATTN: Finance - REFUND  
P.O. Box 300011  
Raleigh NC 27622-3011

## Tips for Submitting Refunds

- If refunding from a central office for multiple provider numbers, submit separate refunds for each provider, as questions regarding one of the providers may impact the processing of all of the refunds when submitted on one check.
- Refund checks must be payable to EDS – REFUND. The bank may reject check made out otherwise, and your refund will not be processed.
- If the refund is in response to a written request from DMA, make the refund check payable to DMA and mail it to the address indicated in the refund request letter.
- If DMA, the DHHS Controller, the Attorney General, or a third-party collections agency has requested a payment, either refund or amount due, make the check payable as the correspondence indicates and mail it to the address indicated. Checks received by EDS are processed as refunds. Payments misdirected to EDS could result in additional actions by DMA, other government agencies, or their agents.
- If a refund is sent due to a claim billing error, it is important to ensure that the credit has processed on the RA, as noted above, prior to resubmitting the claim. This will eliminate any possibility of the resubmitted claim being denied due to a duplicate claim.

- If completing the **Medicaid Provider Refund Form**, save a copy of the form to the computer local drive so that providers have easy access to the form.

Once refunds are entered into the system, the following data will appear on the next RA distributed to the provider:

- The Financial Items section will contain a listing of refunds issued and processed for the provider. EOB 0113 is indicated for any refund transaction, including those applied to history.
- Refunds on claims older than 18 months (or about 540 days) must be applied to claims history unless there is a more recent adjustment on the claim to which the refund can be applied. Refunds applied to claims history will not automatically bring about any penalties and interest from being assessed.