

Due to the number of variables involved with adjustments, it is always advisable to contact provider support [provider.support@odmrdd.state.oh.us or (800)617-6733] *before* entering an adjustment. These are just a few examples of common adjustments. Please note that “zero” adjustments are taken out of the next adjustment cycle. There is no longer a “hold-it” on zero adjustments.

In the context of Medicaid waiver claims processing, **adjustments are corrections to paid claims**. Due to additional processing requirements, **adjustments are not processed within the standard 21-day claims processing timeline**. Due to the number of variables present in processing adjustment claims, ODMRDD will not be able to tell providers when the adjustments will take effect. Providers must keep track of their adjustment reports.

Adjustments may be required for a variety reasons, such as:

- a. Claim, in its entirety, was submitted and paid in error.
- b. Number of units of service submitted and paid was incorrect.
- c. Service code submitted and paid was incorrect.
- d. Claim was paid at an incorrect service rate.
- e. Patient liability was not correctly reported after 18 months.
- f. An individual receiving services entered a nursing home or passed away.

a. CLAIMS SUBMITTED AND PAID IN ERROR: If claims were paid for services, which were not actually delivered, sufficiently documented, or were inappropriate for reimbursement, the Provider **must** submit an adjustment to correct the error. The Provider **must** submit a claim for the same day of service, service code (as the original paid claim), and enter a zero (0) in the units of service column. This entry indicates that there were no units of service delivered on the indicated day of service. **The adjustment for the incorrectly paid claim will be deducted from future claims payment(s).**

b. INCORRECT UNITS OF SERVICE: If claims are paid for an incorrect number of units of service, an adjustment **must** be submitted to correct the number of units of service paid.

NOTE: The key to submitting proper unit difference adjustments is to **resubmit the claim for the correct number of units** of service delivered, and **NOT** the difference between the correct number of units of service delivered and the actual number of units of service paid.

EXAMPLE: If 20 units of service for a specific Service Code was paid for a specific date of service and the provider determines that the correct number of units of service was actually 25, the provider should resubmit a claim for the original month billed and day of service, the original service code, and the **correct** total units of service (which in this example is 25). The claims processing system will reference the paid claims history to determine that 20 units of service were previously paid and the provider is due an adjustment of 5 units of service. The additional units of service will be processed for payment. On the contrary, if 20 units of service for a specific service code were paid for a

specific date of service, and the provider determines that the correct number of units of service was actually 15, the provider should resubmit a claim for the original month billed and day of service, the original service code and the correct total units of service (which in this example is 15). The claims processing system will reference the paid claims history to determine that 20 units of service were previously paid and the provider owes an adjustment of 5 units of service.

The overpayment will be deducted from payment of future claims.

c. INCORRECT SERVICE CODE: If services were paid with an incorrect service code; the provider **must** submit an adjustment to correct the error. The **adjustment would consist of two steps.**

Step 1: Enter the original day of service, the original service code that was paid and zero (0) units of service. This entry indicates that there were no units of service delivered on that day.

Step 2: This step cannot be taken for two (2) billing cycles after **Step 1** was processed. Enter the same day of service, with the correct service code and the actual number of service units delivered. The net effect of the two entries would be the payment of the correct claim and an adjustment to the incorrectly paid claim. **The adjustment for the incorrectly paid claims will be deducted from future claims payment(s).**

d. INCORRECT SERVICE RATE: If claims were submitted and paid with an incorrect service rate, the Provider should submit an adjustment to correct the error. Re-submit the claim, using exactly the same information but with the correct rate. For instance:

If a provider bills for Homemaker/personal care 1:1 [APC], and enters 41 instead of 411 in the Usual Customary Rate field, they would resubmit the claim with the same information, but would put 411 in the UCR field. The system will reference the billing history and cause an adjustment to pay out for the difference.

e. PATIENT LIABILITY ADJUSTMENTS: If patient liability was never submitted on the claim the provider must go back to first day or days of the month it was not entered and resubmit the information. If the wrong amount of patient liability was entered, go back to the date of the error and enter in the correct amount. Patient liability submitted in error, can be corrected by re-submitting the claim with the same information, but entering zeros (0) in the other source amount column.

f. AN INDIVIDUAL RECEIVING SERVICES ENTERED A NURSING HOME OR PASSED AWAY: The county board notifies the PAWS unit of this occurrence.

ADJUSTMENT PRINTOUTS: It is to your benefit to print copies of any/all adjustment report information .

Keep the information so that when adjustments are seen at the top of the voucher report you have the ability to reference this information and reconcile.

Please Note: Adjustments take additional time to process through the MBS system.