

# Electronic Claim Adjustments

## Professional, Facility, and Dental Claims

September 2023



DEPARTMENT OF  
**PUBLIC HEALTH &  
HUMAN SERVICES**

# Void or Void/Replace Function, Communications, and Tips

## Function

- Electronic adjustments replace or void a prior **paid** claim.
- The adjustment is sent “as the claim should be” not “as it was submitted” meaning that what is sent is the entire new claim. There is no logic to compare and merge existing claims via adjustment; the adjustment is processed as received.
  - **Example** – Original Professional claim has 3 lines; one line needs to have the billed amount updated. Key the Adjustment with all three lines “as the claim should be.” If the adjustment is sent with only the updated charge line, the claim will be replaced with the one-line claim. If the claim was submitted with a paperwork attachment, this needs to be included again.
  - **Example** – Original Dental claim has two lines; one line was reported with an incorrect tooth number. Key the adjustment with both lines using the correct tooth number. If the claim was submitted with a paperwork attachment, this needs to be included again.
  - **Example** – Original claim was billed with Big Sky Waiver provider type. SDMI Waiver provider type is selected for the new claim. The claim will process under the SDMI provider type. All previous claim information must be re-entered.
  - **Example** – Original claim was span-billed with one line and an incorrect per-diem with a prior authorization number. The adjustment is keyed with the correct billed charge, but the prior authorization number was not entered. The claim will deny for missing prior authorization number.
- Only **paid claims** (including those paid at \$0) can be adjusted. **Only the 17-digit MMIS Individual Claim Number (ICN) from the remittance advice is valid for adjustments.** Any other value will reject as not found.



# Void or Void/Replace Function, Communications, and Tips

## Communications

- [Claim Jumper Volume XXXVI Issue 12 - December 2021](#)
- [Claim Jumper Volume XXXVII Issue 4 - April 2022](#)

The following **cannot** be adjusted electronically:

- Claims over 12 months old (use the Individual Adjust Request form)
- Claims that have already been adjusted (use the ICN of the adjusted claim instead)
- Claims that are over lines (split or overflow claims)
- Encounter claims
- Pharmacy claims via 837
- Financial adjustments (also referred to as gross adjustments)
- Denied or in-process (suspended) claims



# Void or Void/Replace Function and Communications, and Tips

## Tips

- Only use the 17-digit MMIS ICN from the remittance advice.
  - The MPATH Provider Services Portal confirmation number is not the ICN assigned by the MMIS.
  - Only adjust paid claims, including those paid at \$0.
  - Always use the most recent paid ICN. If a claim has already been adjusted, do not use the original ICN, use the ICN from the adjusted claim.
- The Help link at the top of each MPATH Provider Services Portal page will take you to the specific user manual section based on the page you are working on.
- Always include previous required information (e.g., prior authorization number, paperwork attachments, Coordination of Benefits, Passport number) to avoid denial.
- If using a template, the template may need to be modified.
- Claim status will not be immediately available. Claim status can be retrieved after MMIS cycle on Tuesdays and Thursdays.



# Professional Claim (CMS-1500) Example

## Example

One-line claim to be adjusted to increase billed charge (also applicable to multi-line or span-bill)

- Select **Claims > Professional Submission** from **myMenu** on the MPATH Provider Services Portal.
- Select the appropriate Provider Type (Enrollment Unit)/Specialty.
- Key claim “as it should be”.
- Include all previous data elements (diagnosis, procedure/modifier, prior authorization number).
- Validate date of service and charge.
- Select the radio button response to **Is this a void or replacement of a previously submitted claim?** (Yes)
  - Choose the applicable option from the drop-down (Replacement of prior claim or Void of prior claim)



# Locating the ICN on the Remittance Advice

AS OF 07/23/2023

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

Provider Agency  
123 Provider Ave

BOZEMAN MT 59715

VENDOR # 000000 REMIT ADVICE # 00000 FT/CHK # 000000 DATE 07/27/2023 PAGE 2

NPI #: 1111111111 TAXONOMY: 332B00000X

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
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PAID CLAIMS - MISCELLANEOUS CLAIM

ID#	Member Name	070123	070123	1.000	T2028 UA	89.70	89.70		
ICN 22345678910111213		PATIENT NUMBER=							
***CLAIM TOTAL*****						89.70	89.70		



# Professional Claim (CMS-1500)

## Provider Type

### Professional Claim Submission Form

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:\*

Provider Name:\*

Program/Waiver:\*

Select Program/Waiver

Select Program/Waiver

Severe Disabling Mental Illness Waiver (SDMI)

Montana Medicaid (HMK Plus)

Developmentally Disabled Waiver (DDP)

Big Sky Waiver

# Professional Claim (CMS-1500)

## Provider Type

▼ Billing Provider

Note : Fields marked with an asterisk \* are required.

NPI/API:*	[ 1111111111
Provider Name:*	Agency Name
Program/Waiver:*	Big Sky Waiver ▼
Specialty:*	Assisted Living Facility
Service Location Address 1:*	
Service Location Address 2:	
City:*	
State:*	MT
ZIP:*	59901-2877
Taxonomy Code: *	251S00000X
Enrollment Unit:*	0000000



# Professional Claim (CMS-1500)

## “As It Should Be” – Increase Billed Charge

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDC	EPSDT	Emergency Service	Family Planning
7/1/2023	7/1/2023	11	T2028	UA	1	\$ \$100	1.00	COB	NDC			

Is this a void or replacement of a previously submitted claim: \* ☒ Yes ☐ No

Select the Medicaid Resubmission Code: \* 

Select

Select

**Replacement of prior claim**

Void of prior claim

Enter the Original MMIS ICN: \*

Is this a void or replacement of a previously submitted claim: \* ☒ Yes ☐ No

Select the Medicaid Resubmission Code: \* 

Replacement of prior cl

Enter the Original MMIS ICN: \*

ID#	Member Name	07012023   07012023	1.000	T2028	UA	89.70	89.70
ICN 22345678910111213		PATIENT NUMBER= <input type="text"/>					

Is there a prior authorization for this claim? \* ☒ Yes ☐ No

Prior Authorization Number: \*

# Professional Claim (CMS-1500)

## “As It Should Be” – Certify and Submit Adjustment

### ▾ Terms and Agreements

**Note** : Fields marked with an asterisk \* are required.

Please key in provider name and NPI/API to certify the information on this form is accurate and terms and conditions have been satisfied.

Provider Name:\* | **Agency Name**

NPI/API:\* | 1111111111



I certify I have read the [Terms and Conditions](#)  that apply to this bill and are made a part thereof.

Submit

Previous

Save and Exit

Cancel

# Professional Claim (CMS-1500)

## “As It Should Be” – Successful Submission

Thank you for your Submission



Your Claim was successfully submitted:

Line Level:

From Date: 7/1/2023 To Date: 7/1/2023 POS: 11 CPT/HCPCS Code: T2028 Modifier: UA Diagnosis Pointer: 1 Charges: \$100 Days/Units: 1.00  
NDC: EPSDT: Emergency Service: Family Planning:  
COB: No data entered by the submitter

Total Charges: \$89.70

Claim Questionnaire

Is this a void or replacement of a previously submitted claim: Yes  
Select the Medicaid Resubmission Code: Replacement of prior claim  
Enter the Original MMIS ICN: 22345678910111213 .....



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# Void or Void/Replace Facility Claim (UB-04)

## “As It Should Be”

**Facility claims are adjusted using the Type of Bill (TOB)**

- Adjusting only the TOB still requires the paper form
- Change the last digit of TOB to 7 (void/replace) or 8 (void) to show the ICN field

Type of Bill:*	Inpatient or Outpatient:*	Statement Period From:*	Statement Period Through:*		
<input type="text" value="0127"/>	<input type="text" value="Inpatient"/>	<input type="text" value="01/01/2023"/>	<input type="text" value="01/01/2023"/>		
Admission Date:*	Admission Hour:*	Admission Type: *	Source of Admission:*	Discharge Hour:*	Member Discharge Status:*
<input type="text" value="01/01/2023"/>	<input type="text" value="00"/>	<input type="text" value="1"/>	<input type="text" value="1"/>	<input type="text" value="00"/>	<input type="text" value="01"/>
Original MMIS ICN:*					
<input type="text" value="12345678901112131"/>					

# Void or Void/Replace Dental Claim (ADA)

## “As It Should Be”

Select the radio button response to **Is this a void or replacement of a previously submitted claim?** (Yes)

- Choose the applicable option from the drop-down (Replacement of prior claim or Void of prior claim)

### Ancillary Claim/Treatment Information

Is this a void or replacement of a previously submitted claim:\* ☒ Yes ☐ No

Select the Medicaid Resubmission Code:\* 

Select

Select

Replacement of prior claim

Void of prior claim

Enter the Original MMIS ICN:\*

Is this a void or replacement of a previously submitted claim:\* ☒ Yes ☐ No

Select the Medicaid Resubmission Code:\* Replacement of prior c

Enter the Original MMIS ICN:\*



# Provider Information Website

[For more information, visit the Provider Information website.](#)

