Social Service Medical
Adjust, Void and Resubmit Claims
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1099 Provider: A provider that receives a 1099 tax document at the end of the year. Except for Individual ProviderOne providers, all providers contracted with DSHS are 1099 providers.

Adjust Claim: To make changes to a paid claim and submit the revised claim to be processed.

Client ID: The client’s ProviderOne ID number, 9 digits followed by WA, ex: 123456789WA

Denied Claim: A claim where one or more denial reasons are present, causing the entire claim to be denied. There is no payment.

Non-Offset Adjustment: A method of recouping overpayments where the debt is sent to the Office of Financial Recovery (OFR) for collection.

Offset Adjustment: A method of recouping overpayments where future payments are reduced until the debt is repaid.

Overpayment: A debt owed to the State. May be due to a voided claim or an adjusted claim that pays less than the original claim.

Paid Claim: A claim where at least one service line was not denied. There may or may not be a payment associated with a paid claim, a claim can be considered paid even if the payment was $0.

Provider ID: The provider’s ID number for ProviderOne, 7 digits. This is the same as the Domain number. You will see this listed on the Authorization with a 2 digit location code such as 01, ex: 123456701.

TCN: Transaction Control Number; also called the claim number, this is an 18 digit number assigned to a claim for tracking purposes.

Voided Claim: A claim that was originally paid, and then later was canceled and the payment taken back.
Overpayments
Overpayments can be generated when a paid claim is voided or adjustment. When a claim is voided it will generate an overpayment because the State has paid out money for a claim that is being cancelled. When adjusting a claim an overpayment may be generated if the new paid amount is less than the original claim paid. There are two choices for how to process an overpayment: an offset or a non-offset adjustment.

**Non-offset:** This is the default option for 1099 providers. The debt (overpayment) is automatically sent to the Office of Financial Recovery (OFR). OFR then contacts you, the provider, to address the debt. You will receive a letter from OFR informing you of the debt and how to correct the overpayment, along with your administrative hearing rights if there is any dispute to the information provided.

**Offset:** For this option, you have to submit an e-mail or call (please see details below on how to do this). In this option, the ProviderOne system will deduct the debt from all paid claims submitted until the debt is satisfied within a 6 month window. The deduction is reflected in the summary on your Remittance Advices (RAs). No letter is generated. After 6 months, if the debt is not satisfied, any remaining balance will be sent to OFR for recovery as a non-offset adjustment.
Overpayments

NON-OFFSET

Any debt sent to OFR will result in an overpayment letter to the provider. There will be a reason code on the letter that gives some information as to why the overpayment was made. Refer to your Remittance Advice (RA) associated with the adjustment, this will be generated the same week as the OP notice is generated, to see the specific days or service lines being recouped.

Below are the most common reason codes, with a description, for adjustments initiated by a state worker:

- **AA** - An audit identified this payment as not being valid.
- **P1** - Goods or services not provided. This may apply to the entire claim or only dates or services. Refer to your RA for additional details.
- **P2** - Goods or services authorized in error. Refer to your RA to see specific dates impacted, and review your authorization list to see any changes made to the authorizations.
- **P3** - Provider not eligible to provide goods or services. This means that you were not eligible for payment for the dates of service that resulted in the overpayment.
- **P4** - Client not eligible to receive goods or services.
- **P5** - Rate paid was incorrect. This could mean that either the unit or daily rate was incorrect or the total amount authorized was incorrect.
- **P6** - Multiple payments were made for the same goods or services.
OFFSET

If you want the debt to be deducted from paid claims as an offset, you can submit a message to the Medical Assistance Customer Service Center (MACSC) via the ‘Contact Us’ web form requesting that the adjustment be processed. Please provide the following information:

- **Provider Number**
- **TCN**
- **P1 Client ID**
- **Adjust as Offset or Non-Offset** *(1099 provider claims are defaulted to Non-Offset)*
- **Description of what changes need to be made and why.**

For example:

- **Provider Number:** 11XXXXX06
- **TCN:** 61xxxxxxxxxxxxxxx000
- **P1 Client ID:** 1XXXXXXXXWA

**Adjust as Offset Description (example):**

*Client responsibility was not taken out of claim, although I received a letter stating that the client received client responsibility. Case manager verified client responsibility was correct in the system.*

MACSC Call Center

**Contact Us web form:**

**Call:** 1-800-562-3022
- Option 4 for Provider Services
- Option 1 for Social Services
Adjust Claims
To adjust a paid claim:

- Log in to ProviderOne using the ‘EXT Provider Social Services Medical’ profile,
- Click on ‘Claim Adjustment/Void’.
The ‘Provider Claim Adjust/Void Search’ page appears. There are search requirements to be aware of when searching for claims.

The ‘Provider NPI’ associated to the domain currently in use will automatically be listed in the Provider NPI dropdown. You can search by:

- TCN *(Transaction Control Number)* or,
- Client ID and Claim Service Period. *(From and To Date)*

**Note:**

Search requests must be for claims submitted within the past 4 years. The Claim Service Period cannot exceed 3 months.
Search Using the TCN:

- Enter the ‘TCN’,
- Click on ‘Submit’. *(Located near the top left corner of the page.)*
Search Using Client ID and Claim Service Period:

- Enter the ‘Client ID’ (client ID ends in WA and is found on the authorization) and,
- Enter ‘Claim Service Period From’ date in MM/DD/YYYY format, (Claim Service To date is optional. Not using this date may return multiple claims.)
- Click on ‘Submit’ (located near the top left corner of the page).
The ‘Provider Claims Adjust Void List’ appears.

To Adjust a Paid Claim:
- Check the box next to the Transaction Control Number (TCN).
- Click on ‘Adjust’.

Note:
The populated list will show the TCN, Date of Service, Claim Status, Claim Charged Amount, Claim Payment Amount, Client ID and the Administration providing services for the client.
The ‘Adjust Professional Claim’ page appears.

The screen is similar to the Billing Screen; however, the page includes an ‘Original Transaction Control Number’ (TCN).

If there has been a change that does not require you to change any data, click ‘Submit’ at this point and finish sending the claim to ProviderOne for processing.

Example:
The rate associated to the service has changed since the claim was submitted and paid. To adjust the claim, do the following:

- Locate the claim,
- Once the claim information loads, select ‘Submit’ and finish the claim submission as you would a new claim.

The claim will be reprocessed using the new authorization data under a new TCN.
In the next few pages, we will explore the different options available when adjusting paid claims.

This includes:
- Modifying Service Line data
- Adding Service Lines
- Voiding Service Lines

Modifying Service Line Data:
- Click on a ‘Service Line Number’,
- The corresponding service line information appears,
- Make needed changes to the data fields.

Note: Diagnosis pointer information does not need to be updated if there is no additional diagnosis being added.
Adjust Claims

- Click on ‘**Update Service Line**’.

- The service line updates with the new information. *(line #2 shown below)*

**Note:**

*Make sure to select ‘**Update Service Line Item**’ rather than ‘**Add Service Line Item**’ unless your adjustment is to add service dates on new lines.*

---

<table>
<thead>
<tr>
<th>Line No</th>
<th>Service Dates</th>
<th>Proc. Code</th>
<th>Modifiers</th>
<th>Diagnosis Ptnrs</th>
<th>Submitted Charges</th>
<th>Units</th>
<th>PA Number</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>02/05/2016 02/05/2016</td>
<td>H2019</td>
<td>1</td>
<td>85</td>
<td>4</td>
<td></td>
<td></td>
<td>Void or Other Service Info</td>
</tr>
<tr>
<td>2</td>
<td>02/26/2016 02/26/2016</td>
<td>H2019</td>
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<td>127.5</td>
<td>6</td>
<td></td>
<td></td>
<td>Void or Other Service Info</td>
</tr>
</tbody>
</table>
Adding Service Line Data:

- Locate and select the claim you wish to update, *(see pgs. 9-12)*
- Enter ‘Basic Service Line’ information,
- Click on ‘Add Service Line’.
- The new service line appears. *(Line #2 shown below)*

![Adjust Claims](image)

**BASIC SERVICE LINE ITEMS**

<table>
<thead>
<tr>
<th>mm</th>
<th>dd</th>
<th>ccyy</th>
<th>mm</th>
<th>dd</th>
<th>ccyy</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Service Date From:</td>
<td></td>
<td></td>
<td>* Service Date To:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of Service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Procedure Code:</td>
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<td></td>
<td>Modifiers: 1:</td>
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<tr>
<td>* Submitted Charges: $</td>
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<td></td>
<td>Diagnosis Pointers: * 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Units:</td>
<td></td>
<td></td>
<td>2:</td>
<td></td>
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</tr>
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</table>

**Medicare Crossover Items**

<table>
<thead>
<tr>
<th>National Drug Code:</th>
</tr>
</thead>
</table>

**Drug Identification**

**Prior Authorization**

**Additional Services**

**Note:** Please ensure you complete all sections on this or another page before adding this service line.

- Click a Line No. below to view/update that Line Item Information.
- Total Submitted Charges: $ 212.50

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Service Dates From</th>
<th>To</th>
<th>Proc. Code</th>
<th>Modifiers</th>
<th>Diagnosis Dates 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Submitted Charges</th>
<th>Units</th>
<th>PA Number</th>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Voiding Service Line Data:

- Locate and select the claim you wish to update, (see pgs. 9-12)
- Determine which line needs to be voided in the ‘Previously Entered Line Item Information’ section,
- Click ‘Void’ at the end of the line you wish to remove,
- The line disappears from the claim, and any subsequent lines will change numbers to match the new order.
Once all service line information is entered and checked for accuracy, click ‘Submit Claim’ at the top of the screen.

Your pop-up blockers must be turned off to allow the Claim Detail screen to appear.

If the pop-up blockers are not turned off, the screen will flash and no pop-up will appear which allows you to complete billing.

**Note:**
If submitting a claim with the pop-up blockers on, the claim information will remain on the screen. Providers should turn off pop-up blockers before logging in to ProviderOne.

Attempting to click ‘Submit Claim’ again will return an error message that says: The information you are trying to submit has been queried by another user.

To remedy this, log out of ProviderOne, turn off your browser’s pop-up blockers, then log in to ProviderOne again and return to the ‘Adjust Professional Claim’ page to begin again.
A message will appear asking, “Do you want to submit any Backup documentation?”

Certain shared services require backup documentation such as a denial from another payer. If required, select ‘Ok’ and upload the needed documentation before continuing to submit the claim.

If no backup documentation is needed, select ‘Cancel’ and continue submitting the claim.
Once you have clicked ‘Submit’ the ‘Adjust Professional Claim Details’ page appears. The adjusted claim will have a new ‘TCN’ number. This allows for tracking of the changes made to the original claim.

Claim details will include the new TCN, Original TCN, Provider NPI, Client ID, Date of Service and Total Claim Charge.

Click on ‘Submit’ to send the adjusted claim to ProviderOne for processing.

Note:
Make sure to click ‘Submit’ on this screen. Failure to do so will result in the claim not being sent to ProviderOne to be processed.

‘No Records Found!’ refers to attachments such as backup documentation. If you did not attach necessary documents earlier you may do so here by clicking ‘Add Attachment’.
Void Paid Claims
To Void a Paid Claim:

- Locate and select the claim you wish to update, *(see pgs. 9-12)*
- Check the box next to the TCN,
- Click on ‘Void Claim’.

**Note:**

Voiding a claim results in the payment being taken back by ProviderOne as a Non-Offset Adjustment, if you want it to be taken back as an Offset Adjustment, contact the MACSC call center. The debt/overpayment is sent to OFR. Voiding of claims should only be done with instructions from MACSC. *(See page 7)*
The ‘Void Professional Claim’ page appears with all the fields greyed out.

- Please note the specific TCN,
- To void this claim, click on ‘Submit’. (Located near the top left corner of the page.)
The ‘Adjust Social Services Claim Detail’ appears. The adjusted claim will have a new ‘TCN’ number. This allows for tracking of the changes made to the original claim.

Claim details will include the new TCN, Original TCN, Provider ID, Client ID, Date of Service and Total Claim Charge.

Click on ‘Submit’ to submit the voided claim.

Note:
Make sure to click ‘Submit’ on this screen. Failure to do so will result in the claim not being sent to ProviderOne to be processed.
‘No Records Found!’ refers to attachments such as backup documentation. Social Service providers will not add attachments.
Resubmit Denied or Voided Claims
To resubmit a denied claim:

- Login to ProviderOne using the ‘EXT Provider Social Services Medical’ profile,
- Click on ‘Resubmit Denied/Voided Claim’.
The ‘Provider Claim Model Search’ page appears. There are search requirements to be aware of when searching for claims.

The ‘Provider NPI’ associated to the domain currently in use will automatically be listed in the Provider ID dropdown. You can search by:

- **TCN** *(Transaction Control Number)* or,
- **Client ID and Claim Service Period** *(From and To Date).*

**Note:**
Search requests must be for claims submitted within the past 4 years. The Claim Service Period cannot exceed 3 months.
Search Using the TCN:

- Enter the ‘TCN’,
- Click on ‘Submit’. *(Located near the top left corner of the page.)*
Search Using Client ID and Authorization Number:

- Enter the ‘Client ID’ (Client ID ends in WA and is found on the authorization) or,
- Enter the ‘Authorization Number’ and,
- Enter ‘Claim Service Period From’ date in MM/DD/YYYY format, (Claim Service To date is optional. Not using this date may return multiple claims.)
- Click on ‘Submit’. (Located near the top left corner of the page.)
The ‘Social Service Claims Model List’ appears.

To Resubmit a Denied or Voided Claim:
- Check the box next to the ‘TCN’.
- Click on ‘Retrieve’.

Note: The populated list will show the TCN, Date of Service, Claim Status, Claim Charged Amount, Claim Payment Amount, Client ID and the Administration providing services for the client.
The billing screen appears.

- The options available for service lines when resubmitting a claim are the same as when adjusting a claim. *(See pgs. 14-18)*
- Changes may be needed to other information in the professional claim as well.
- Common reasons a claim may be denied include:
  - Incorrect Taxonomy,
  - Missing Social Service Authorization number or authorization is in error status,
  - Diagnosis code is too general.

**Note:**

*You must turn off your pop-up blocker before you begin billing.*

*Asterisks (*) denote required fields.*

*The billing information is taken directly from the authorization.*

*Exporting the authorization to an Excel file allows you to copy and paste information for accuracy.*

*Check your authorization before each billing.*

*Authorizations may change.*
Once all information is entered and checked for accuracy, click ‘Submit Claim’ at the top of the screen.

Your pop-up blockers must be turned off to allow the Claim Detail screen to appear.

If the pop-up blockers are not turned off, the screen will flash and no pop-up will appear which allows you to complete billing.

Note:

If submitting a claim with the pop-up blockers on, the claim information will remain on the screen. Providers should turn off pop-up blockers before logging in to ProviderOne.

Attempting to click ‘Submit Claim’ again will return an error message that says: The information you are trying to submit has been queried by another user.

To remedy this, log out of ProviderOne, turn off your browser’s pop-up blockers, then log in to ProviderOne again and return to the billing screen to start over.
A message will appear asking, “Do you want to submit any Backup documentation?”

Certain shared services require backup documentation such as a denial from another payer. If required, select ‘Ok’ and upload the needed documentation before continuing to submit the claim.

If no backup documentation is needed, select ‘Cancel’ and continue submitting the claim.
The ‘Submit Professional Claim Details’ page appears. The resubmitted claim will have a new ‘TCN’ number. This allows for tracking of the changes made to the original claim.

Click on ‘Submit’ to send the adjusted claim to ProviderOne for processing.

Note:
Make sure to click ‘Submit’ on this screen. Failure to do so will result in the claim not being sent to ProviderOne to be processed.

‘No Records Found!’ refers to attachments such as backup documentation. Social Service providers will not add attachments.
# Common Adjustment & Denial Codes

Below is a short list of common Adjustment Reason and Remarks Codes you may find on your Remittance Advice (RA):

<table>
<thead>
<tr>
<th>RA adjustment reason/remark code/description</th>
<th>Possible causes</th>
<th>Provider action</th>
</tr>
</thead>
<tbody>
<tr>
<td>142 - Monthly Medicaid patient liability amount.</td>
<td>Client responsibility (participation) applied to the claim</td>
<td>You must collect this amount from the client</td>
</tr>
<tr>
<td>198 - Precertification/authorization exceeded</td>
<td>Social Service Authorization Approved Units have already been claimed</td>
<td>Contact your case worker if you question the number of units authorized</td>
</tr>
</tbody>
</table>
| 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication | 1. Claimed dates of service are not within the authorization period  
2. The authorization line is in error                                                       | 1. Contact your case worker if you have questions about the authorization dates  
2. Contact your case worker if you have questions about authorization errors                     |
| 18 - Exact duplicate claim/service                                  | 1. Claimed the same units on two different lines for the same day, or  
2. Claim is an exact duplicate of one already submitted                                           | 1. Adjust the claim and report the number of units on a single claim line  
2. No action is needed if duplication was unintended.                                             |
| 177 - Patient has not met the required eligibility requirements     | The client is not financially eligible                                                                                                               | Contact your case worker if you have questions                                                    |
| A1 - Claim/Service denied                                          | The authorization is in cancelled status                                                                                                            | Contact your case worker if you have questions                                                    |
| B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service | Your contract may be expired.                                                                                                                         | Contact your contract manager or case worker if you have questions                                 |
| N54 - Claim information is inconsistent with pre-certified/authorized services | Authorization line is in error                                                                                                                       | Contact your case worker if you have questions                                                    |
| N63 - Rebill services on separate claim lines                      | A separate claim line is required for each date of service for the service/procedure code entered                                                   | If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim |
| N302 - The number of Days or Units of Service exceeds our acceptable maximum | Too many units claimed. Example: Provider billed two units on monthly units or provider billed two units on daily units with one day date span | Change the number of units to the correct amount and resubmit your claim                           |