Title	Description
Policy and Procedure Name:	**Request for Adjustment or Void of a Denied, Prior Paid, or Partially Paid Bill**
Policy #:	BRM-2024-01
Code/Rule/Policy Reference:	OAC 4123-6-08; 4123-6-37.1; 4123-6-37.2; 4123-6-37.3; 4123-3-23 ; 4123-6-04.3; *Bill and Adjustment Submission Timeliness policy (PDF)*
Effective Date:	1/1/2024
Supersedes:	All policies, procedures, directives, and memos regarding adjustments or void requests that predate the effective date of this policy.
History:	New 1/1/2024
Review date:	1/1/2029

I. POLICY PURPOSE

The purpose of this policy is to define the provider-initiated process to request an adjustment or void of a previously submitted bill and the associated submission requirements. This policy will define and clarify the reasons BWC will permit an adjustment to a prior paid, partially paid or denied bill, so long as the adjustment request meets bill timeliness requirements as referenced in the Ohio Administrative Code and clarified in the Provider Billing and Reimbursement Manual policy titled, *Bill and Adjustment Submission Timeliness (PDF) policy.*

BWC will clarify when differences may exist between the institutional and non-institutional provider bill types for submission requirements. It is important to note that adjustment requests will not be accepted when the provider is appealing a bill denial. Bill grievances and dispute resolution must follow the applicable policy and procedures as outlined in the Provider Billing and Reimbursement Manual for those defined purposes.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval, and adjudication of an adjustment or void for a previously paid or partially paid bill, when the provider, BWC or MCO discovers an error. When an adjustment results in an overpayment, the BWC Recovery policy applies, although that policy content will not be repeated within this policy.

III. DEFINITIONS

Adjustment: A hard copy or electronic request to make a change to a previously paid, partially paid or denied bill for payment reconsideration. This type of request is submitted

as a replacement to the original bill. The adjustment results in a reversal of the initial bill and replaces the initial bill with the corrected revised bill and may result in a payment difference including additional payment; no change in payment; or a recovery. Examples include but are not limited to submission of identified institutional late charges; a change in charges billed incorrectly; or a change in procedure code billed incorrectly. An adjustment is submitted as bill type 0XX7 or under claim frequency code "7".

Billing Appeal: A billing appeal is a bill grievance where the provider is not satisfied with the amount of payment and EOB received from the MCO. This does not include a dispute regarding the BWC fee schedule rate. An example includes a bill denied for missing medical documentation; or a request for reconsideration of payment of a denied line item when the provider used an edit override modifier such as modifier 25.

Bill Type (Institutional): A four-digit code that is used to identify if an institutional bill is an original bill, a replacement bill or a voided bill submitted on the UB-04. Please note: for BWC, the UB-04 is only accepted for institutional billing. All other providers must bill on the professional provider bill, CMS-1500.

- **0XX1:** Represents an institutional bill type for an initial bill. Bill type 0111 is an inpatient bill. Bill type 0131 is an outpatient bill.
- **0XX7**: Represents an institutional bill type for a replacement bill adjustment request. Bill type 0117 is an inpatient replacement bill. Bill type 0137 is an outpatient replacement bill.
- **0XX8**: Represents an institutional bill type for a void or cancel of a prior bill that BWC has paid for recoupment of the payment made. Bill type 0118 is an inpatient void. Bill type 0138 is an outpatient void.

Claim frequency code (Professional): A code that is used to identify if the bill is an original bill, a replacement bill or a voided bill from a professional provider submitted on the CMS-1500. The claim frequency code is a single digit for non-institutional bills.

- "1" indicates this is an original bill;
- "7" indicates this is a replacement bill; and
- "8" indicates the bill is a voided bill.

Resubmission code: Title of the form locator field 22 on the CMS-1500 equating to claim frequency code. For purposes of this policy the resubmission code will be referenced as claim frequency code.

Replacement bill: An adjustment request to reprocess a previously submitted bill with provider or MCO identified corrections. See adjustment.

Void: A reversal of an incorrectly paid bill, which can be initiated by a provider, MCO or BWC. Examples include when a payment is made to an incorrect provider; for treatment to an incorrectly identified injured worker; or when the bill type was incorrectly identified. This type of transaction is intended to recover a payment made in error.

IV. POLICY

A. General Bill Identifier Requirements for Adjustment and Void Requests: Institutional and non-institutional providers may submit adjustment and void requests in hard copy or electronic format as follows:

1. Institutional providers using the CMS-1450 (i.e., UB-04) form must:
   a. Follow National Uniform Billing Committee (NUBC) standards for completion, except where otherwise indicated in BWC policy; and
   b. Use bill type 0XX7 to submit an adjustment request; or
   c. Use bill type 0XX8 to submit a void request.
2. Non-institutional providers using the CMS-1500 form must:
   a. Follow National Uniform Claim Committee (NUCC) standards for completion, except where otherwise indicated in BWC policy; and
   b. Submit claim frequency code 7 for an adjustment request; or
   c. Submit claim frequency code 8 for a void request.
3. Institutional provider bill type 0XX5 (late charges only) is not accepted. Institutional providers must submit late charges as a replacement bill type 0XX7.
4. Form references are included in Appendix 1.

B. Adjustments

1. Adjustment requests to replace a prior bill are subject to all BWC billing guidelines, including, but not limited to completeness, data validity and clinical editing.
2. Adjustments may be submitted to correct bills previously paid, partially paid or denied.
3. When a provider is appealing a full or partial denial of a previously submitted bill:
   a. The provider would follow the bill grievance procedures to appeal the denial decision to the MCO.
   b. If the provider's appeal results in approval of payment, the MCO will initiate the process for the adjustment.
4. **Ineligible Reasons for Adjustment:**
   a. The following changes cannot be submitted as an adjustment:
      i. Pay-to provider number; or
      ii. Servicing provider number; or
      iii. Injured worker claim number; or

iv. Institutional bill type (e.g., inpatient bill type 0111 to outpatient bill type 0131 or vice versa).

b. The original bill paid in error to an incorrect provider, claim or under the wrong institutional bill type, must be voided.
   i. Reimbursement made in error to the wrong servicing or pay-to provider must be recovered from the incorrectly paid provider.
   ii. A new bill must be submitted to pay the correct provider or claim or institutional bill type.

5. **Required Data for Adjustment Requests:** All adjustment requests must include the:
   a. BWC original invoice number to match to the bill being replaced; and
   b. The reason for the adjustment.
      i. For non-institutional providers, the reason for the adjustment must be included as a note in the note field.
      ii. For institutional providers the reason for the adjustments request must be reported as a two-digit alpha-numeric condition code specifically identified as reason codes in Appendix 2.
         a) Only one reason code is permissible per adjustment request.
         b) Reason code D9 must be reported when:
            i) None of the reason codes listed apply (e.g., modifying the condition codes); or
            ii) More than one of the reason codes applies (e.g., adding a new line to the bill which includes new code and new charges); or
            iii) The adjustment reason is to override the statute of limitations for billing timeframes and the proof of timely filing is included.
            iv) When D9 is reported, provide a brief description of the corrections being made in the remarks field.

C. Void of a prior paid bill

1. Providers may submit requests for voids (i.e., reversals) of previously paid bills.
2. **Reason Codes:** For institutional providers the reason for the void requests must be reported as a two-digit alpha-numeric condition code specifically identified as reason codes in Appendix 2.
3. The void request must contain:
   a. The original BWC bill invoice number; and
   b. The billed information previously submitted; and
   c. The reason for the void.
      i. Institutional providers must use the 2-digit reason code identified in Appendix 2.
      ii. Non-institutional providers must include a reason in the notes field.

D. Requirements to remit overpayments to the MCO.

1. Providers must remit the full payment amount resulting from any payment error immediately, upon discovery of the overpayment.
    a. When an entire bill will be voided, the provider must remit payment to the MCO, with each void submission.
    b. When an overpayment will result from the submission of an adjustment and:
        i. The overpayment is identified in advance, the provider is required to remit to the MCO the amount of the overpayment with the adjustment request.
        ii. The overpayment was not identified in advance:
            a) The MCO will communicate the resulting overpayment and recovery action to the provider; and
            b) The provider must remit the overpayment recovery to the MCO in full; or
            c) Appeal the recovery to the MCO.
            d) After an overpayment has been collected in full, the adjustment shall be reprocessed.

Appendix 1:

EDI and Hard Copy Form References

Bill types 0XX7 and 0XX8 submitted electronically shall follow the American Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837I (institutional) Version 5010A2 format, except where otherwise indicated in BWC policy. Non-institutional providers shall follow the ANSI ASC X12N 837P (Professional) Version 5010A2 format, except where otherwise indicated.

Data Element	UB04 Field Locator	837I Field	CMS1500 Field	837P Field
Injured worker claim number	60	NM109	1a	NM109
Injured worker name	8	NM103, NM104	2	NM103, NM104
Original Reference Number: BWC Original Claim Identification Number (CIN)	64	CLM05-C0203	22	CLM05-C0203 REF=F8 is used to note the BWC CIN in the loop.
Reason code for adjustment	18-28	HI*BG:C02202	Not applicable	Not applicable
Description of correction when reason code D9 is used	80	NTE, NTE01, NTE02	19	NTE, NTE01, NTE02
Resubmission code	N/A		22	CLM05-C0203

Appendix 2

Reason Codes: BWC only accepts the following reason codes for institutional providers:

Adjustment Reason Codes

UB04 Bill Type	Reason Code	Explanation
0117 or 0137	D0 (zero)	Change to service dates
0117 or 0137	D1	Change to charges
0117 or 0137	D2	Change in revenue codes/HCPCS/CPT
0117 or 0137	D4	Change in diagnoses or ICD procedure code
0117 or 0137	D9	Any other change, including when multiple reasons above apply, and includes when adding late charges.

VOID Reason Codes

UB04 Bill Type	Reason Code	Explanation
0118 or 0138	D5	VOID – Cancel only to correct provider number
0118 or 0138	D6	VOID- Cancel only to repay a duplicate payment; MCO identified overpayment; or cancellation of an outpatient bill containing services required to be included on inpatient bill; or claim number.