



Medicaid Claims and Billing Guide

Claim Corrections, Adjustments, and Appeals

Quick Reference Table

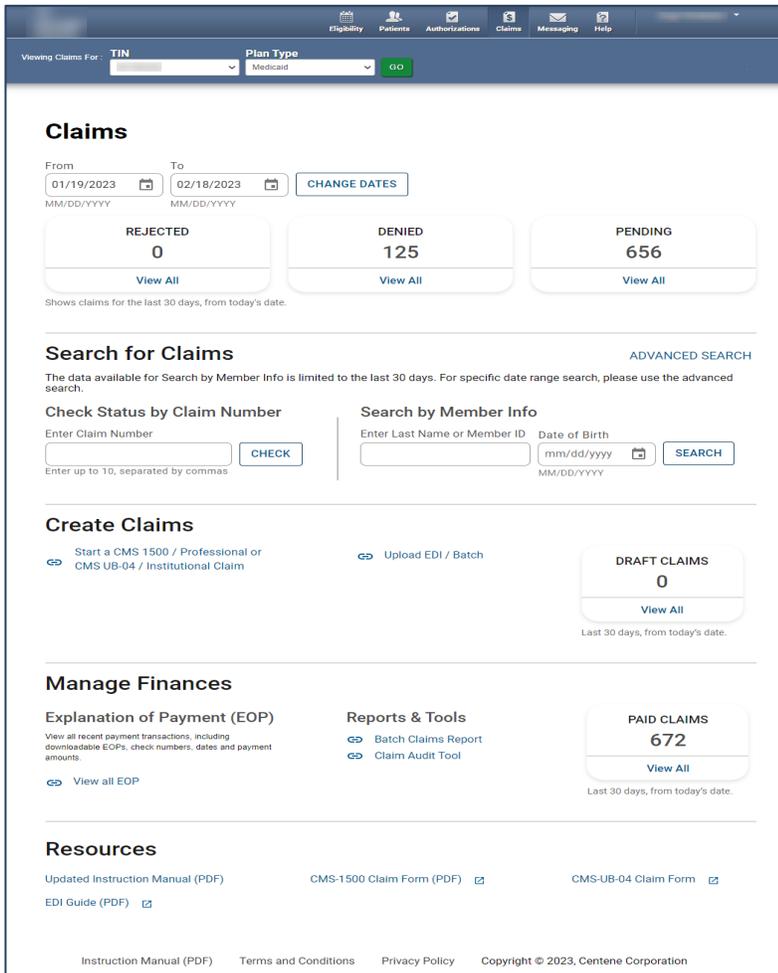
Action	Definition	Timely Filing	Method	Additional Notes
Correction	For claims that include a correction to the initial claim submission. For example, to correct invalid or incorrect information in the initial submission.	A claim can be resubmitted within 365 days from the date of service, or 120 days from the last date of adjudication/remit; whichever is later.	EDI, provider secure web portal, or to the address below: https://provider.mimeridian.com/ Meridian Michigan ATTN: Claims Department PO Box 8080 Farmington, MO 63640-8080 Health Plan Name: Meridian Transaction Type: Fee for Service BHT06 = CH Clearing House Payer ID: MHPMI	Please see Pg 2 for Detailed Web Portal Instructions.
Reconsideration	To dispute original claim determination. Complete and submit dispute to request additional review.	A claim can be resubmitted within 365 days from the date of service, or 120 days from the last date of adjudication/remit; whichever is later.	Secure provider portal or to the address below: https://provider.mimeridian.com/ Meridian Michigan ATTN: Claims Department PO Box 8080 Farmington, MO 63640-8080	Claim reconsiderations do not include decisions related to retro authorization and adverse medical necessity determination.
Appeal	Post service appeal- A formal request for re-evaluation of a decision made based on plan policy or contract requirement related to denied authorization or medical necessity of services rendered. Post service claim appeal- A formal request for re-evaluation of a decision made based on a claim denial related to benefit limitations or failure to authorize services.	Appeals must be filed within one year from the date of service. Meridian will allow an additional 120-day grace period from the date of the last claim denial, provided that the claim was submitted within one year of the date of service.	Secure provider portal, fax, or address below: https://provider.mimeridian.com/ Fax: 833-592-0658 Meridian Michigan Appeals Department PO Box 8080 Farmington, MO 63640-4402	

Secure Provider Portal: Claim Corrections

Providers have the ability to correct a claim and attach documentation to any claim online. Attachment functionality is available for new claim submissions, claim corrections and claim appeals.

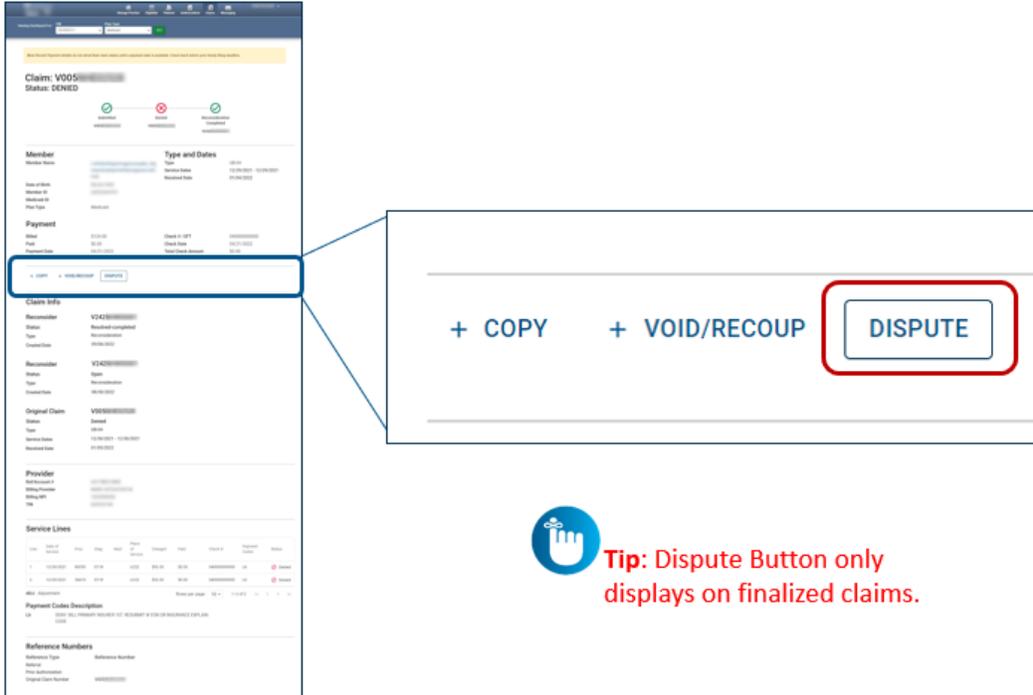
Review the steps below to see the process for correcting a claim and attaching documentation.

1. Log into the Secure Provider Portal: <https://provider.mimeridian.com/>
2. Use the navigation bar at the top to select the **Claims** feature.
3. **Search for Claims** by the CLAIM NO to populate the claim detail.



The screenshot shows the 'Claims' section of the Meridian Secure Provider Portal. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are filters for 'Viewing Claims For' (TIN) and 'Plan Type' (Medicaid), with a 'GO' button. The main content area is titled 'Claims' and features a date range selector (From: 01/19/2023, To: 02/18/2023) and a 'CHANGE DATES' button. Three summary cards are displayed: 'REJECTED 0', 'DENIED 125', and 'PENDING 656', each with a 'View All' link. Below these is a 'Search for Claims' section with an 'ADVANCED SEARCH' link. The search section includes a note about data availability and two search methods: 'Check Status by Claim Number' and 'Search by Member Info'. The 'Create Claims' section offers options to 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' or 'Upload EDI / Batch', with a 'DRAFT CLAIMS 0' card. The 'Manage Finances' section includes 'Explanation of Payment (EOP)', 'Reports & Tools' (Batch Claims Report, Claim Audit Tool), and a 'PAID CLAIMS 672' card. The 'Resources' section lists links for 'Updated Instruction Manual (PDF)', 'CMS-1500 Claim Form (PDF)', 'CMS-UB-04 Claim Form', and 'EDI Guide (PDF)'. The footer contains links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

4. Once the claim is opened, click the **dispute** button.

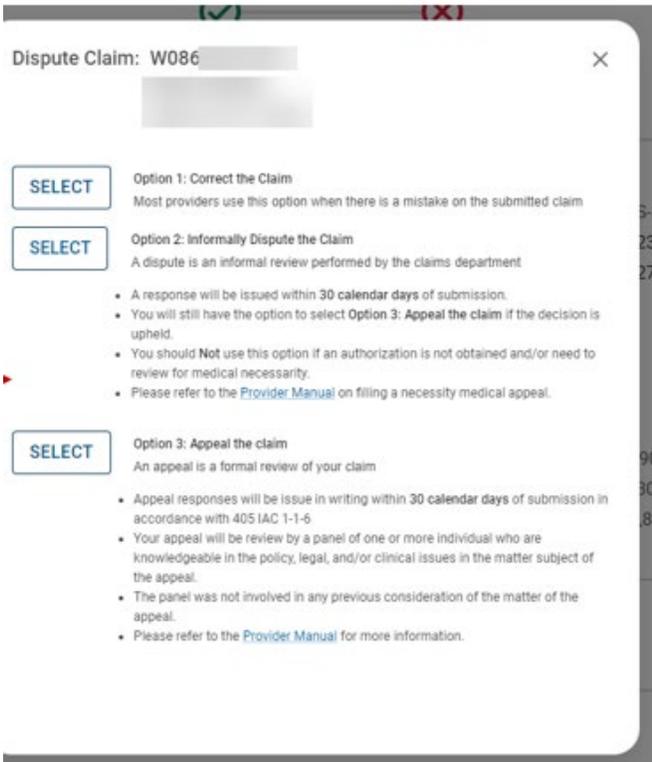


The screenshot shows a claim details page for claim ID V005, which is in a 'DENIED' status. A callout box highlights the action menu containing three options: '+ COPY', '+ VOID/RECOUP', and 'DISPUTE'. The 'DISPUTE' button is highlighted with a red border.



Tip: Dispute Button only displays on finalized claims.

5. Once you click dispute, you will have three options to select from. **Select Option 1: Correct the claim**



The 'Dispute Claim: W086' dialog box presents three options for disputing the claim:

- Option 1: Correct the Claim**
Most providers use this option when there is a mistake on the submitted claim.
- Option 2: Informally Dispute the Claim**
A dispute is an informal review performed by the claims department.
 - A response will be issued within **30 calendar days** of submission.
 - You will still have the option to select **Option 3: Appeal the claim** if the decision is upheld.
 - You should **Not** use this option if an authorization is not obtained and/or need to review for medical necessity.
 - Please refer to the [Provider Manual](#) on filing a necessity medical appeal.
- Option 3: Appeal the claim**
An appeal is a formal review of your claim.
 - Appeal responses will be issue in writing within **30 calendar days** of submission in accordance with 405 IAC 1-1-6
 - Your appeal will be review by a panel of one or more individual who are knowledgeable in the policy, legal, and/or clinical issues in the matter subject of the appeal.
 - The panel was not involved in any previous consideration of the matter of the appeal.
 - Please refer to the [Provider Manual](#) for more information.



6. In the general information tab, you will fill out all required information displayed below. Click **Next**.

* Required fields

Patient's Account Number*	<input type="text"/>	26
Statement Dates*	From <input type="text" value="04/05/2024"/> To <input type="text" value="04/05/2024"/> <small>**Changing the statement dates from ICD 9 effective dates to ICD 10 effective dates or vice versa, may invalidate current diagnosis codes.</small>	
Date of current illness, Injury, Pregnancy (LMP)	Select Type... <input type="text" value="MM/DD/YYYY"/>	14
Other Date	Select Type... <input type="text" value="MM/DD/YYYY"/>	15
Hospitalization	From <input type="text" value="MM/DD/YYYY"/> To <input type="text" value="MM/DD/YYYY"/>	18
Additional Claim Information:	<input type="text" value="XXXXXXXXXXXX"/>	19a
Outside Lab?	<input type="radio"/> Yes <input checked="" type="radio"/> No	20
Prior Authorization Number	<input type="text" value="XXXXXXXXXXXX"/>	23a
CLIA Number	<input type="text" value="XXXXXXXXXXXX"/>	23b
Amount Paid	<input type="text" value="XXXX.XX"/>	29

[Next →](#)

7. On the diagnosis codes page, you will need to verify any diagnosis code. If a code is incorrect, please click **remove**. Then select **next**.

THIS SECTION:
Diagnosis Codes
Diagnosis Code and Additional Insurance information.

You are correcting a claim for: XXXXXXXXXX

← BackNext →

*** Required field**

ICD Version Indicator* ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* (Enter diagnosis code and click on Add button)

21.

R509 -- FEVER, UNSPECIFIED Remove X

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8. On the service lines page, click on **save/update** to each service line details, as necessary, and click **Next**.

* Required field Delete Save / Update

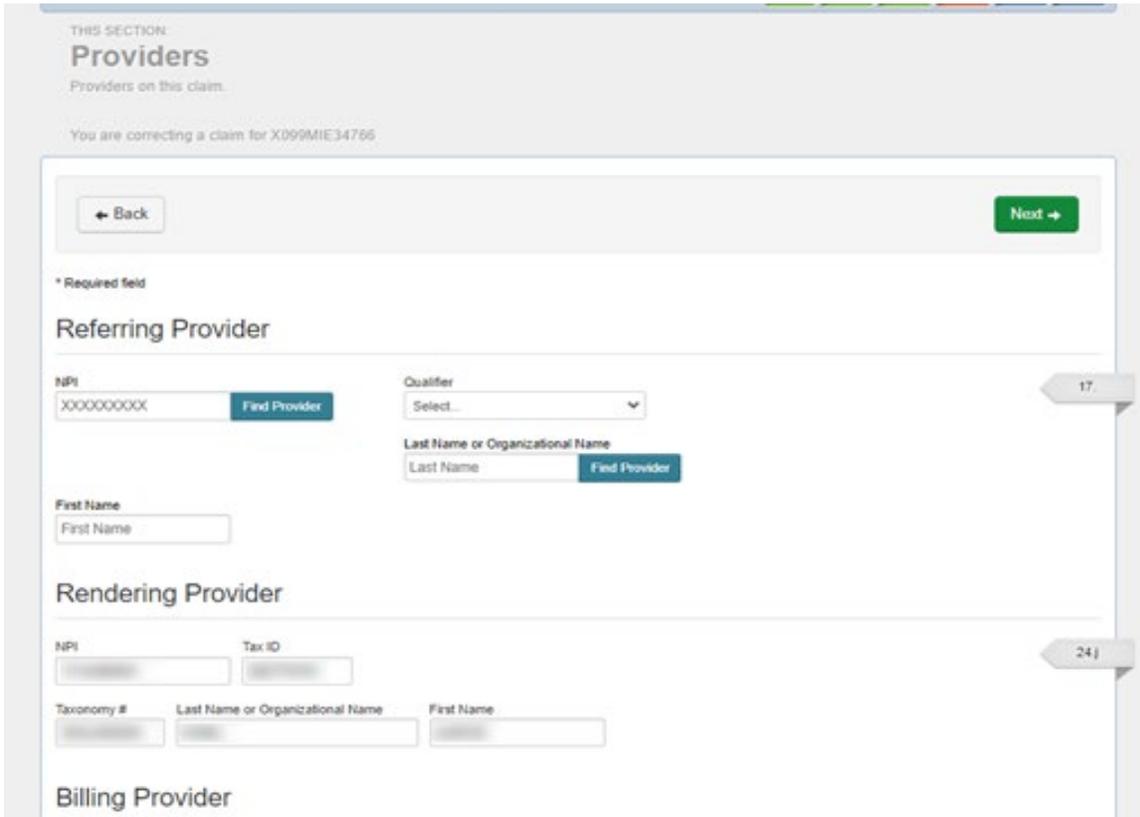
Now Viewing Line 1: 98966 / \$28.00

Dates of Service*	From 04/05/2024 To 04/05/2024	24.a
Place of Service*	19 -- OFF CAMPUS-OUTPATIENT	24.b
Emergency	Yes No	24.c EMG
Procedure Code*	98966	24.d
Modifiers	XX Add Please enter the modifier and click the Add button.	
Diagnosis Code(s)*	<input checked="" type="checkbox"/> R509 - FEVER, UNSPECIFIED	24.e
Charges*	28	24.f
Units / Minutes / Days*	1.0 Type * UN - Units	24.g
Family Planning	Yes No EPSDT Select...	24.h
NDC	NDC	NDC
Supplemental Information	Supplemental Information	

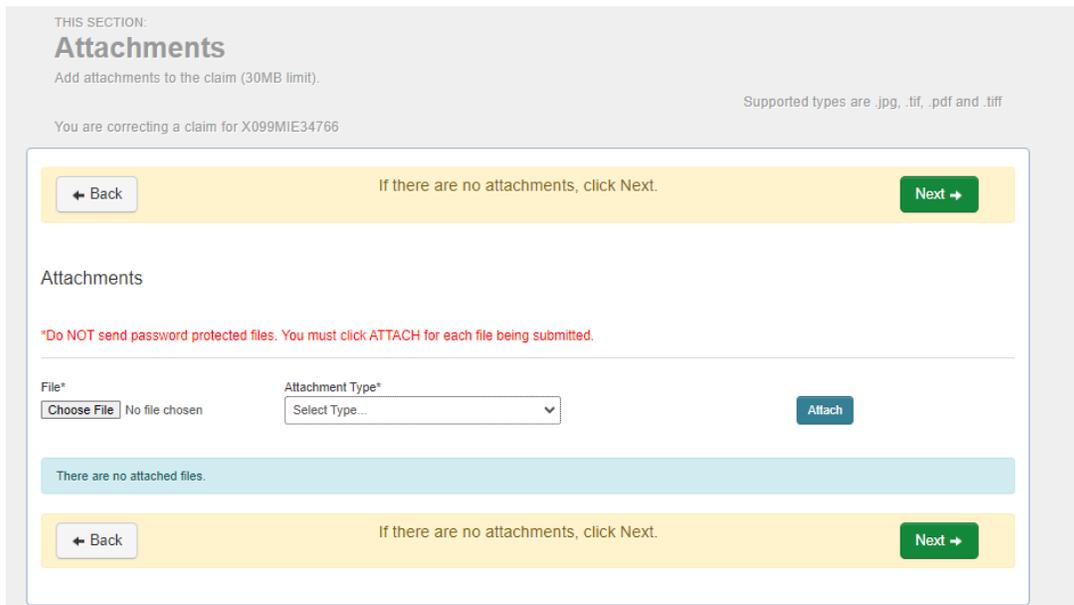
Delete Save / Update

Next →

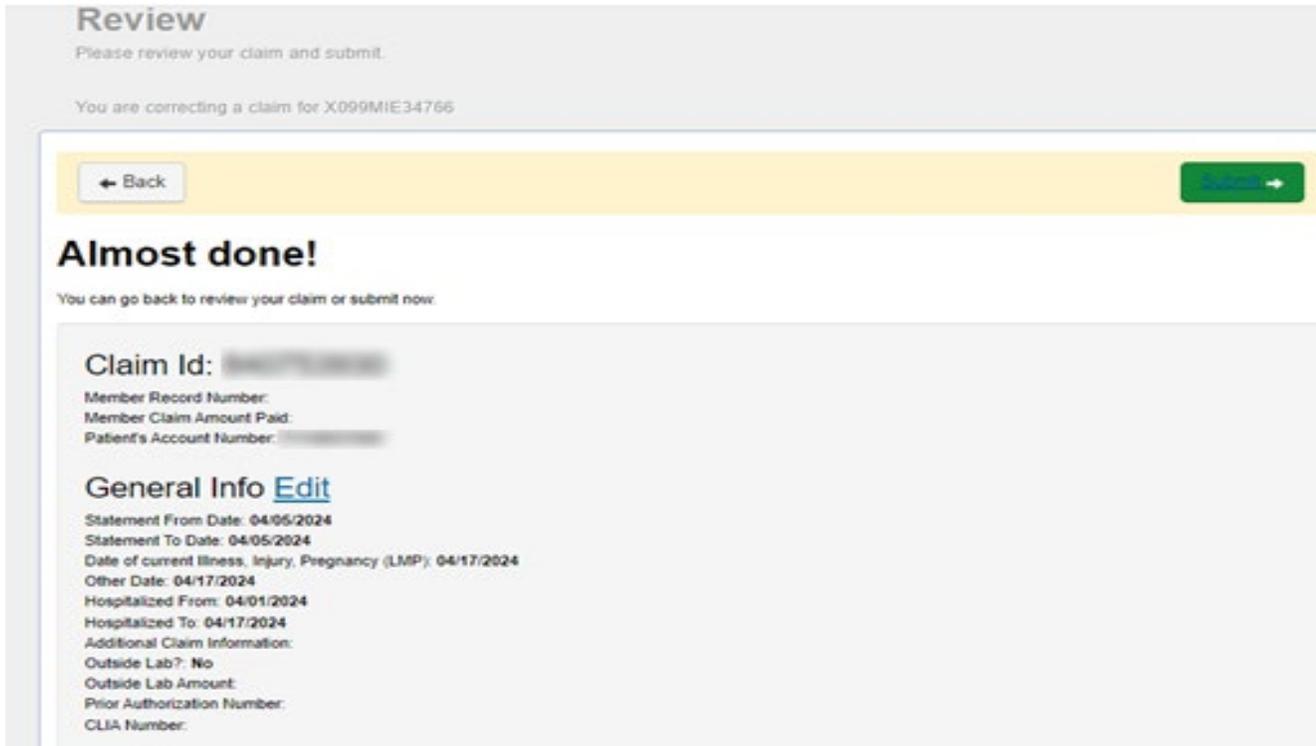
9. The provider information will remain the same from the original claim. Click **Next**.



10. On the attachments page, click browse to attach supporting documents. Please note: attachments are optional if you are submitting a corrected claim. If providers are submitting a corrected claim and do not need to attach any documents, then hit **next** to be taken to the review page.



11. The review page is used to review and confirm claim details. Once confirmed, click **submit**



12. When the claim is successfully submitted, the **web/ref#** will display for confirmation.

Please note: web/ref# is not a claim number. It only serves as confirmation that the claim was submitted using the secure provider portal.

