# Home Health & Hospice

# Claims Correction

Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Guide

**Chapter 5** 





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**Note:** It is the responsibility of Medicare providers to ensure the information submitted on your billing transactions (Requests for Anticipated Payment (RAPs), Notices of Election (NOEs), claims, adjustments, and cancels) are correct, and according to Medicare regulations. CGS is required by the Centers for Medicare & Medicaid Services (CMS) to monitor claim submission errors through data analysis, and action may be taken when providers exhibit a pattern of submitting claims inappropriately, incorrectly or erroneously. Providers should be aware that a referral to the Office of Inspector General (OIG) may be made for Medicare fraud or abuse when a pattern of submitting claims inappropriately, incorrectly, or erroneously is identified.

#### Disclaimer

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## **Claims Correction Menu Options**

The Claims Correction Menu (FISS Main Menu option 03) allows you to:

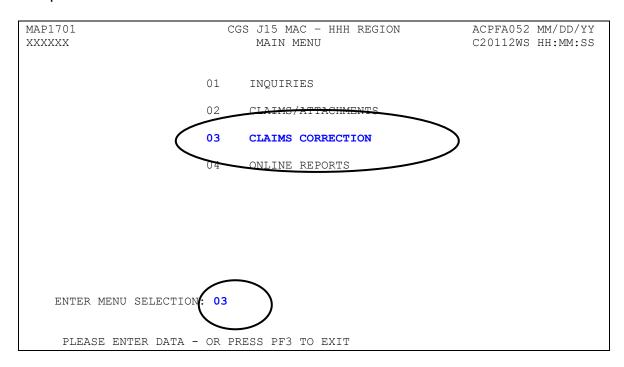
- ☑ Correct claims in the return to provider (RTP) status/location (T B9997)
- ☑ Adjust paid or rejected claims
- ☑ Cancel paid claims or Requests for Anticipated Payments (RAPs)

Even though this option also allows correction of attachments (e.g., home health), CGS does not accept those electronically via direct data entry (DDE). Therefore, correcting these attachments electronically is not discussed in this guide.

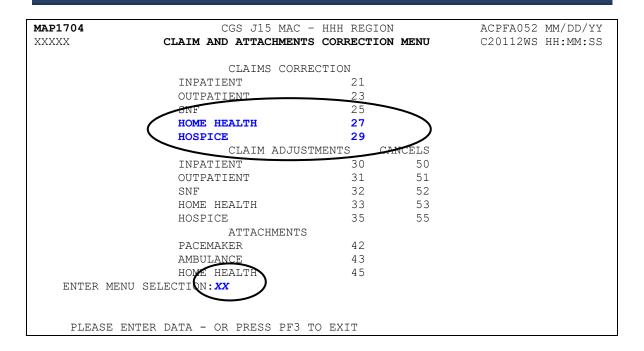
→ All FISS direct data entry (DDE) screens display information in the top right corner that identifies the region (ACPFA052), the current date, release number (e.g., C20112WS) and the time of day. This information is for internal purposes only and is used to assist CGS staff in researching issues when screen prints are provided.

#### Access the Claims Correction Menu

1. From the FISS Main Menu, type 03 in the **Enter Menu Selection** field and press *Enter*.



2. The Claim and Attachments Correction Menu screen (Map 1704) appears:



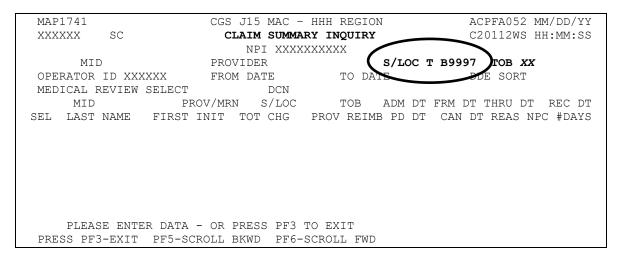
**Note:** Throughout this section, the terms billing transaction and claims are used interchangeably to describe claims, notice of elections (NOEs), notices of election termination/revocation (NOTRs), and requests for anticipated payment (RAPs).

## **Correcting Claims**

When a claim is submitted, FISS processes it through a series of edits to ensure the information submitted on the claim is complete and correct. If the claim has incomplete, incorrect or missing information, it will be sent to your Return to Provider (RTP) file for you to correct. Claims in the RTP file receive a new date of receipt when they are corrected (F9'd) and are subject to the Medicare timely claim filing requirements. See the "Note" on page 8 of this chapter for additional information on Medicare timely filing guidelines.

- Enter the Claims Correction option (27 or 29) that matches your provider type and press *Enter*. Claims that have been returned to you for correction (RTP) are located in status/location T B9997.
- The Claim Summary Inquiry screen (Map 1741) appears. The S/LOC field will default to the status/location T B9997. This is commonly referred to as your Return to Provider (RTP) file. Your cursor will be located at the MID field.

- → Change Request 8486 (<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R116MSP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R116MSP.pdf</a>) implemented the ability for providers to enter and correct Medicare secondary payer (MSP) claims and MSP adjustments via the FISS Direct Data Entry (DDE), in addition to the American National Standard Institute (ANSI) ASC X12N 837 5010 (electronic) format. In FISS DDE, Claim Adjustment Segment (CAS) information must be submitted. Access the "MSP Payment Information" screen (MAP1719) by pressing F11 from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing F6 to display the "MSP Payment Information" screen for "Primary Payer 2." See the "Medicare Secondary Payer Billing and Adjustments" (<a href="http://www.cgsmedicare.com/hth/education/materials/pdf/MSP\_Billing.pdf">http://www.cgsmedicare.com/hth/education/materials/pdf/MSP\_Billing.pdf</a>) quick resource tool for assistance with submitting MSP claims.
- → Since Medicare billing transactions may encounter different edits while processing, claims and adjustments may need correction more than one time, and for multiple reasons. Therefore, it is important to verify that all required claim data is present and that the information is complete and correct prior to resubmitting billing transactions.
- 3. Type your NPI in the NPI field. To move the cursor to the NPI (National Provider Identifier) field, hold down the Shift key and press the Tab key. You cursor will automatically move to the NPI field.
- → Only the claims for the NPI entered will appear.



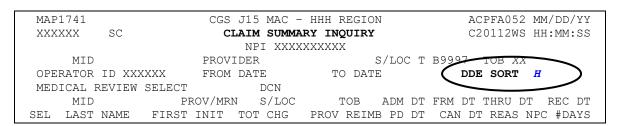
→ The **S/LOC** field defaults to T B9997. Because you are accessing Map 1741 from the Claims Correction menu, only claims in a T B9997 status/location will display.

- The TOB field automatically displays the first two digits of the default type of bill (TOB) based on the claim correction option that you selected. A list of the default TOBs is provided below.
- → If you need to view claims with a different TOB, you will need to change the default TOB, or you may remove the first two digits from the TOB field to view claims with all TOBs for your provider type.

Claim Correction Option	Default TOB
27	33
29	81

The **DDE SORT** field on Map 1741 allows you to sort claims for correction. This is especially helpful if you have a large number of claims to correct. If you wish, enter one of the following characters in the DDE SORT field to sort your claims.

Type:	To sort by:
D	Receipt Date
Н	Medicare number
М	Medical Record Number
N	Last Name
R Reason Code	



5. Press *Enter* to see a list of all claims that require correction that match the criteria you entered (TOB and/or DDE SORT). In this example, because an 'H' (Medicare number) sort type was used, the list of claims is sorted by the patient's Medicare number.

MAP1741	CGS J15 MAC -	HHH REGION	ACPFA052	MM/DD/YY			
XXXXXX SC	CLAIM SUMMAI	RY INQUIRY	C20112WS	HH:MM:SS			
	NPI XXXX	XXXXXX					
	PROVIDER		В В В В В В В В В В В В В В В В В В В				
OPERATOR ID XXXXXX	FROM DATE	TO DATE	DDE SORT	H			
MEDICAL REVIEW SELEC	CT DCN						
MID	PROV/MRN S/LOC	TOB ADM DI	FRM DT THRU D	r rec dt			
SEL LAST NAME FIRS	ST INIT TOT CHG	PROV REIMB PD DT	CAN DT REAS I	NPC #DAYS			
XXXXXXXXXX XXXXXX	к т в999	97 XXX 0921XX	0101XX 0131XX	0215XX			
SMITH	J 272.94	0216X	x 37402	11			
XXXXXXXXXX XXXXXX	к т в999	97 XXX 0726XX	0801XX 0805XX	0215XX			
JONES	s 975.00	0831x	x 37402	06			
XXXXXXXXXX XXXXXX	к т в999	97 XXX 0803XX	0803XX 0806XX	0215XX			
DOE	J 1250.00	0920X	X 37402	10			
PLEASE ENTER DAT	PLEASE ENTER DATA - OR PRESS PF3 TO EXIT						
PRESS PF3-EXIT PF5-	-SCROLL BKWD PF6-	SCROLL FWD					

- → If no claims appear after you press Enter, there are no claims with this TOB for your facility that you need to correct today. We recommend that you check the Claims Correction area at least once per week. Checking more often is encouraged.
- → If your facility submits claims with different bill types (TOB), you may want to leave the TOB field blank. This will ensure that all claims applicable to your provider type display. The Claim Count Summary Inquiry screen (option 56), can be used to view the number of claims that are located in the RTP file (T B9997), and the first two digits of the type of bill. This will ensure you are aware of the various types of bills you have that need correction. Refer to the "Chapter 3 Inquiry Menu" (<a href="http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter 3-inquiry\_menu.pdf">http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter 3-inquiry\_menu.pdf</a>) section for information about option 56.
- 6. If claims appear, you will see a two-line summary of each claim's information. Up to five claims can display per page on Map 1741. Use the F6 key to scroll forward (F5 to scroll backward) through the entire list of claims you have to correct. To determine what needs to be corrected, you will need to select each claim. To select a claim, press your Tab key until your cursor moves under the SEL field and is to the left of the Medicare number (MID field) of the claim you want to view.

	MAP1741			CGS	J15 M	IAC -	HHH RE	GIO	N			ACP	FA052	M	1/DD/	YY
	XXXXXX	SC		CI	LAIM SU	MMARY	INQUI	RY				C20	112WS	H	:MM:	SS
	NPI XXXXXXXXX															
	MID			PROVI	DER			S	/LOC	T E	39997	T	OB XX	•		
	OPERATOR I	D XXX	XXX	FROM	DATE		TO D	ATE			D	DE	SORT			
	MEDICAL RE	CVIEW	SELECT		DCN	ſ										
	MID		PF	ROV/MRN	I S/L	OC	TOB		ADM D	T E	RM D	ТТ	HRU D	Т	REC	DT
	SEL LAST N	IAME	FIRST	INIT	TOT CH	IG P	ROV RE	IMB	PD D	$\Gamma$	CAN	DT	REAS	NPO	C #DA	YS
(  _	xx <b>x</b> xxxxx	X X	XXXXX		T	в9997	XXX		0921X	x c	)101X	x 0	131XX		0215	XX
V	MITH			J	272.	94			0216	XX			37402	2	11	

7. Type an S in the **SEL** field and press *Enter*. You can only select one claim at a time. After you press Enter, Page 01 (Map 1711) of the claim appears. The reason code(s) appears at the bottom left corner of the screen.

MAP1711 PAGE 01 CGS J15 MAC - HHH REGION	ACPFA052 MM/DD/YY
XXXXXX SC INST CLAIM UPDATE	C20112WS HH:MM:SS
MID XXXXXXXXXX TOB XXX S/LOC S B0100 OSCAR XXXXXX	SV: UB-FORM
NPI XXXXXXXXX TRANS HOSP PROV PROCESS NEW	MID
	TAXO.CD:
STMT DATES FROM 0101XX TO 0131XX DAYS COV N-C	CO LTR
LAST SMITH FIRST JAMES MI E	DOB 01011931
ADDR 1 101 MAIN ST 2 ANYWHERE, IA	
3 4	CARR:
5 6	LOC:
ZIP 52001 SEX M MS ADMIT DATE 0921XX HR 00 TYPE 9 SR	
	09 10
OCC CDS/DATE 01 02 03 04	* *
06 07 08 09	
SPAN CODES/DATES 01 02	03
04 05 06	07
08 09 10	FAC.ZIP
DCN	MOD ADD THE
VALUE CODES - AMOUNTS - ANSI	MSP APP IND
01 61 99916.00 02 03 06 06	
03 06 09	
37402	
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8	-NEXT PF9-UPDT

- 8. Press *F1* to access the narrative of the first reason code. The Reason Code Inquiry screen (Map 1881) appears. The narrative provides you with information about what needs to be corrected.
- → CGS provides a list of the top claim submission errors (CSEs) causing claims to reject or go to the RTP file. For assistance on how to correct claims in your RTP file for the top CSEs, and how to avoid future billing errors, refer to the "Top Claim Submission Errors (Reason Codes) and How to Resolve" Web page at <a href="http://www.cgsmedicare.com/hhh/education/materials/cses.html">http://www.cgsmedicare.com/hhh/education/materials/cses.html</a> on the CGS website.

MAP1881		J15 MAC -	HHH REGIO	)NI	acprans'	2 MM/DD/VV
	REASON COD				C20112W	
AAAAA SC	REASON COL	ES INQUIRI				
					MNT: CMSSTI	
	EFF MSN					
IND CODE TYPE	DATE REAS	DATE	DATE	ST/LOC	ST/LOC LO	OC IND
1 37402 E	080100		7	Γ	T	
TPTP A B	NPCD A B	HD CPY A	B NE	3 ADR	CAL DY	C/L C
		NARRATIVE				
	CE CLAIM AND THE					
	THERE IS NO CLAI					
	AN THIS CLAIM'S F			JDD WIII	1 11 1111100011	DIIIE
**	IN IIIIS CLAIM S F	NOM DAIL.				
	THE THE CHEPTH	DIII MADD	TO DOLLAT	mo miin	HITOMODIA DI	
	THAT THE CURRENT		~			
	ISTORY BILL IS AN	•	THE CURRE	ZNI BITI	TYPE MUST	BE AN
81X AND AN 82X M	MUST EQUAL A HIST	ORY 82X.				
PROCESS C	COMPLETED	NO MORE DAT	A THIS TY	YPE		
PRESS PF3-EXIT	PF6-SCROLL FWD	PF8-NEXT				

- 9. Once you have reviewed the narrative, press *F*3 one time to return to the claim. Make the correction and press *F*9. If the system automatically takes you back to the Claim Summary Inquiry screen (Map 1741), the claim has been corrected. You will also notice that the two-line summary for that claim no longer appears on your list of claims to correct. Select the next claim to correct or press *F*3 to return to the Claims Correction and Attachments Menu.
  - If you press *F*9 and are not returned to Map 1741 automatically, one or more errors still exist. Press *F*1 again to see the narrative for the next reason code. When you have finished reviewing the narrative, press *F*3 one time to return to the claim. Make your correction and press *F*9. Repeat this process (F1, F3, F9) until the claim has been corrected, and you are returned to Map 1741.
- → More than one reason code may appear in the lower left-hand corner of Page 01 of the claim. Pressing F1 displays the narrative for the first reason code. You should correct the reason codes one at a time. Sometimes, by correcting the first code, other related codes will also be corrected. Sometimes, new codes will appear. Continue to work through the reason codes, one at a time, until you are returned to Map 1741 and the claim is eliminated from your claim correction list.
- → If you need to change information on a revenue code line (HCPCS, modifier, units, charges, or date of service), instead of typing over the incorrect information, you need to delete the incorrect revenue code line and re-key the correct information. The instructions "Deleting Revenue Code Lines" and "Adding Revenue Code Lines" can be found later in this chapter.

- → If, after reviewing the error(s), you decide that you would rather resubmit the billing transaction than to correct it, you may do so. Duplicate claim editing does not apply to claims in the RTP file. CGS encourages you to suppress the view of any billing transaction that you do not intend to correct. Instructions for suppressing the view of claims are found later in this chapter.
- → In some situations, you will need to work other claims (e.g., submit a prior claim, correct a prior claim, etc.) before being able to correct a claim in the RTP file. For example, before being able to correct a hospice claim with a sequential billing error, a prior claim may need to be submitted or corrected. Home health providers may need to resubmit and wait for the episode's RAP to finalize before being able to correct the episode's final claim out of the RTP file. If you realize once you are in a claim that you will be unable to correct it, press F3 to return to Map 1741. Access the claim at a later time once you have fixed other claim issues related to this particular claim.
- → In some situations, CGS staff may add information in the REMARKS field on Page 04 of the claim to assist you in correcting the claim. Check Page 04 of the claim when you are correcting the claim to see if additional information has been entered.

Note: Claims are available in your RTP file for up to 36 months (see the "Note" below regarding timely filing). After 36 months, the claim will purge off of FISS. If you choose not to correct the claim in RTP, we strongly encourage you to suppress the view of the claim, which will remove the claim from your RTP file sooner. This will help to limit the number of claims that are viewable in your RTP file, and will assist you in avoiding duplicate claim submission errors. Refer to the "Suppress View" information later in this chapter. As a Medicare provider, you are accountable to ensure the information you submit on your claim is correct, and according to Medicare regulations.

When claims are corrected from the RTP file, a new receipt date is assigned. Therefore, it is important to remember that Medicare timely claim filing requirements apply. Correct your claims as soon as possible. The "#DAYS" field on Map 1741 tells you how long the claim has been in your RTP file. If the #DAYS field is blank, the claim just went to the RTP file during the nightly system cycle. Additional information about timely filing requirements is available on the "Timely Claim Filing Requirements" (http://www.cgsmedicare.com/hhh/education/materials/timely\_claim\_filing\_req.ht\_ml) CGS Web page.

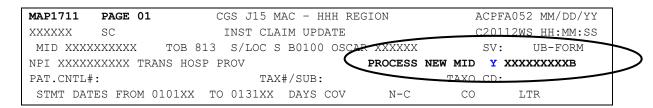
→ In the example below, the claim has been in the RTP file for 11 days.

MAP1741	CGS J15 MAC - HHH	REGION A	CPFA052 MM/DD/YY
XXXXXX SC	CLAIM SUMMARY IN	QUIRY	20112WS HH:MM:SS
	NPI		
MID	PROVIDER	S/LOC T B9997	TOB XX
OPERATOR ID XXXXX	FROM DATE TO	DATE DDE	SORT
MEDICAL REVIEW SELECT	DCN		
MID Pl	ROV/MRN S/LOC	TOB ADM DT FRM DI	THRU DT REC DT
SEL LAST NAME FIRST	INIT TOT CHG PROV	REIMB PD DT CAN I	T REAS NEC #DAYS
XXXXXXXXX XXXXXX	Т В9997	XXX 0921XX 0101CC	0131XX 0215XX
SMITH	J 272.94	0216XX	37402 <b>11</b>

#### **Correcting a Medicare Number**

A Medicare number can only be corrected when a claim is located in the RTP status/location (i.e., T B9997). To correct a Medicare number:

- 1. Select the claim from your RTP list on Map 1741.
- On Page 01 of the claim, tab to the PROCESS NEW MID field.
- 3. Type Y in the **PROCESS NEW MID** field. The cursor will move one space to the right after you type the Y. Enter the correct Medicare number.
- 4. Press *F9*.



→ If a billing transaction is in the finalized FISS S/LOC "P B9997" and contains an incorrect Medicare number, you will need to cancel the original billing transaction, and submit a new billing transaction with the correct Medicare number. See the information under the heading "Canceling a Claim/RAP" later in this chapter for instructions on using FISS to cancel claims.

#### **Deleting Revenue Code Lines**

If you need to change information on a revenue code line (HCPCS, modifier, units, charges, or date of service), instead of typing over the incorrect information, you need to delete the incorrect revenue code line and re-key the correct information. To delete a revenue code line:

- Key the letter "D" in the first position of the revenue code on the line that you
  wish to delete. If there are multiple lines to delete, key the letter "D" on each
  line you wish to delete.
- Press the HOME key on your keyboard so that your cursor is placed in the upper right hand corner of the screen (the "Page" field).
- Press *Enter*. The revenue code line(s) with the letter "D" will be removed, and FISS will automatically reorder the remaining revenue code lines.
- If the claim's total charges are changing due to the deletion of revenue code line(s), update the total charge amount on the 0001 revenue code line to reflect the correct amount.

MAP1712	PAGE 02	2 CGS.	T15 MA	С – нн	HREGION			ACDEA	.052 MM/D	n/vv
	IAGE 02	cos (	JIJ M		INDOION				'	'
XXXXXX	SC	INS	CLAI:	M UPDAT	ΓE			C2011	2WS HH:M	M:SS
						REV	CD PA	AGE 01		
MID XXX	XXXXXXX	TOB XXX S/I	LOC S	В9997	PROVIDE:	R XXX	XXXXX	XXX		
UTN		PROG	REP	PAYEE	RRB E	XCL ]	IND	PROV	VAL TYPE	
			TOT	COV					SERV	RED
CL REV	HCPC N	MODIFS RATE	UNIT	UNIT	TOT CH	ARGE	NCOV	CHARGE	DATE	IND
1 0023	2AGL1		00060	00060					0215XX	
2 0270					5	0.00			0215XX	
3 0551	G0299	104.910	00002	00002	10	0.00			0222XX	
<b>(</b> 4 <b>D</b> 551	<b>)</b> 50299	104.910	00004	00004	10	0.00			0229XX	
5 0001					25	0.00				

#### Adding Revenue Code Lines

To add a revenue code line, key the new revenue code line under the 0001 line, and then press the HOME key on your keyboard so that your cursor is placed in the "Page" field (in the upper left hand corner of the screen). Press *Enter*. You do not need to re-key the revenue codes that were already entered. FISS will automatically reorder the revenue code line that you added. If the claim's total charges are changing due to the addition of revenue codes lines, update the total charge amount on the 0001 revenue code line to reflect the correct amount.

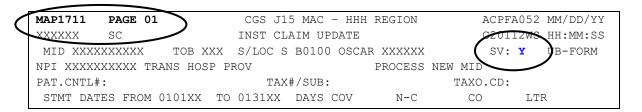
MAP1712	PAGE 02	CGS .I	15 MAC - H	HH REGION	ACPFA052 MM/DD/YY		
XXXXXX	SC SC	INST CLAIM UPDATE C20112WS HH:MM:SS					
AAAAAA	50	INSI	CLAIM OFD	REV CD P			
MID XXXX	XXXXXX	TOB XXX S/L	OC S B9997		1102 01		
	ΛΛΛΛΛΛ						
UTN		PROG	REP PAYEE	RRB EXCL IND	PROV VAL TYPE		
			TOT COV		SERV RED		
CL REV	HCPC MOI	DIFS RATE	UNIT UNI	T TOT CHARGE NCOV	CHARGE DATE IND		
1 0023	2AGL1		00060 0006	0	0215XX		
2 0270				50.00	0215XX		
3 0551	G0299	104.910	00002 0000	2 100.00	0222XX		
4 0551	G0299	104 910	00004 0000	100.00	0229XX		
5 0001				350.00			
6 0551	G0300		00003 0000	3 100.00	0217XX		
7.							
	ROCESS CON		PLEASE CO				
PRESS PI	F2-171D PI	F3-EXIT PF5-UP	PF6-DOWN	PF7-PREV PF8-NEXT	PF9-UPDT PF11-RIGHT		

#### **Suppress View**

Occasionally, you may have claims in RTP that you do not need to correct. Although FISS does not allow you to delete a claim in RTP, we strongly recommend that you suppress the view of a claim you choose not to correct to avoid duplicate billing errors. Suppressed claims will move to the status/location I B9997 (I=inactivated), and will no longer appear on your list of claims in your RTP file. The following steps explain how to suppress the view of a claim.

This action cannot be reversed. Please make sure that you want to suppress the view of the claim before following the steps below. Suppressed claims (I B9997 status/location) will still appear when viewing claims in option 12 (Claim Summary Inquiry screen).

- 1. Select the claim from your RTP list on the Claim Summary Inquiry screen (Map 1741).
- 2. Using your Tab key, move to the **SV** field in the upper right-hand corner on Page 01 of the claim.
- 3. Type Y in the **SV** field and press F9.



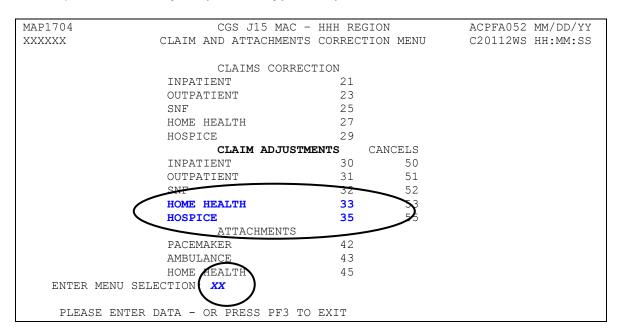
- 4. The system will automatically return you to Map 1741 and the claim will no longer appear on your RTP list.
- → After suppressing the view of a claim, it will no longer display in the RTP file; however, when viewing the Claim Inquiry (option 12) or Claim Count Summary (option 56) screens, the claim may still appear in status/location T B9997 for several weeks, until FISS purges suppressed claims to the "I" status.

### **Adjusting Claims**

At times, you may need to adjust a claim after it has been processed to make changes (e.g., add or remove services). Claim adjustments can be made to paid or rejected claims (i.e., status/location P B9997 or R B9997). However, adjustments cannot be made to:

- a line item that has been denied by Medical Review;
- a Request for Anticipated Payment (RAP) (Refer to the "Canceling a Claim/RAP" found later in this chapter.);
- a Notice of Election (NOE) (Refer to the "Canceling a Hospice Notice of Election or Benefit Period" (<a href="http://www.cgsmedicare.com/hhh/">http://www.cgsmedicare.com/hhh/</a> education/materials/cancel hos notice.html) Web page for information about canceling an NOE);
- claims in status/location R B7501 or R B7516 (post-pay MSP review); and
- claims in status/location R B9997 for the following reasons:
  - ✓ Eligibility (entitlement date or date of death)
  - ✓ Medicare number change
  - ✓ Untimely claims (past timely filing deadline)
  - ✓ Duplicates
- → For additional information about adjustments, refer to the "Adjustments/Cancels" Web page at <a href="http://www.cgsmedicare.com/hhh/education/materials/Adjustments Cancels.h">http://www.cgsmedicare.com/hhh/education/materials/Adjustments Cancels.h</a> tml on the CGS website.
- → Medicare timely filing requirements apply to claim adjustments. Refer to the Medicare Claims Processing Manual, (CMS Pub. 100-04) Ch. 1, §70.5, at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf</a> for additional information. In addition, refer to the "Timely Claim Filing Requirements" (<a href="http://www.cgsmedicare.com/hhh/education/materials/timely\_claim\_filing\_req.html">http://www.cgsmedicare.com/hhh/education/materials/timely\_claim\_filing\_req.html</a>) CGS Web page.

- → If the original claim information did not post to the Common Working File (CWF), the claim cannot be adjusted. Instead, a new claim must be resubmitted with the correct information. You can verify whether a claim posted to CWF by reviewing the TPE-TO-TPE (tape-to-tape) field, which is found on FISS screen Map 171D. For more information about using Inquiry option 12 to access this screen, refer to the TPE-TO-TPE field information under the Map 171D Field Descriptions found in "Chapter 3 Inquiry Menu" (<a href="http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter\_3-inquiry\_menu.pdf">http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter\_3-inquiry\_menu.pdf</a>) of this guide.
- 1. To adjust paid or rejected claims, enter the Claims Adjustments option (33 or 35) that matches your provider type and press *Enter*.



- 2. The Claim Summary Inquiry screen (Map 1741) appears.
- → Your cursor will be located at the MID field.

MAP1741	CGS J15 MAC - HHH	REGION	ACPFA052 MM/DD/YY
XXXXXX SC	CLAIM SUMMARY INQU	IRY	C20112WS HH:MM:SS
	NPI		
MID	PROVIDER	S/LOC P	TOB XX
OPERATOR ID XXXXXX	FROM DATE T	O DATE	DDE SORT
MEDICAL REVIEW SELECT	DCN		
MID PF	ROV/MRN S/LOC	TOB ADM DT	FRM DT THRU DT REC DT
SEL LAST NAME FIRST	INIT TOT CHG PROV	REIMB PD DT	CAN DT REAS NPC #DAYS
PLEASE ENTER DATA -	- OR PRESS PF3 TO EXI	T	
PRESS PF3-EXIT PF5-SCF	ROLL BKWD PF6-SCROLL	FWD	

- 3. Type your NPI in the **NPI** field. To move the cursor to the NPI (National Provider Identifier) field, hold down the Shift key and press the Tab key. Your cursor will automatically move to the NPI field.
- 4. After typing your NPI, your cursor will move to the **MID** field. Type the beneficiary's Medicare number.
- 5. After typing the Medicare number, press the tab key to place your cursor after the "P" in the S/LOC field. The S/LOC field defaults to P to display claims in P (Paid) status/location. Type B9997 after the P. Or, if the claim you want to adjust was rejected, change the "P" to an "R" and type B9997.
- 6. The **TOB** field automatically displays the first two digits of the default type of bill based on the adjustment option that you selected. If you need to adjust a claim with a different type of bill, you will need to change the default TOB, or you may remove the values from the TOB field to search claims with all TOBs. A list of the default TOBs is provided below.

Claim Adjustment Option	Default TOB
33	33
35	81

- → Please note that effective for home health episodes beginning on or after October 1, 2013, the 33X TOB was discontinued.
- 7. You may also enter the 'From Date' and 'To Date' of the claim, but that is optional.

- 8. Press *Enter*. Any claims matching the criteria you entered (MID, S/LOC, TOB, and/or FROM/TO DATE fields) will appear.
- → Note: Not all claims that are accessible using this function are appropriate to adjust.

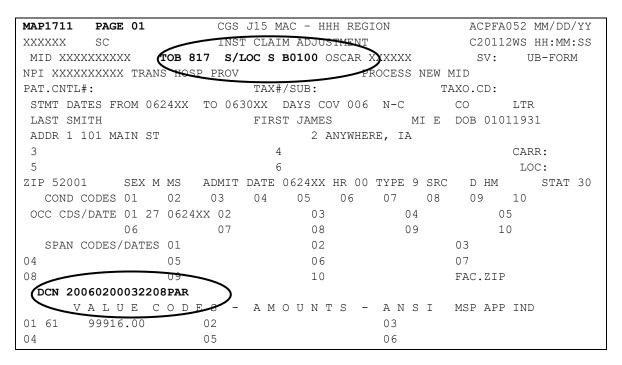
MAP1741		CGS J15 MAC - I	HHH REGIO	N	ACPFA052 MN	M/DD/YY
XXXXXXX SC		CLAIM SUMMARY	INQUIRY		C201411P F	HH:MM:SS
		NPI XXXXXXX	XXX			
MID XXX	XXXXXXX PI	ROVIDER	s	/LOC P	TOB XX	
OPERATOR ID	XXXXXXX FI	ROM DATE	TO DATE		DDE SORT	
MEDICAL REV	IEW SELECT	DCN				
MID	PROV	MRN S/LOC	TOB	ADM DT	FRM DT THRU DT	REC DT
SEL LAST NAM	ME FIRST IN	T TOT CHG PI	ROV REIMB	PD DT	CAN DT REAS N	PC #DAYS
xxxxxxxxx	XXXXXX	Р В9997	XXX	0624XX	0624XX 0630XX	0720XX
SMITH	J	839.40	432.00	0816XX	37192	
xxxxxxxxx	xxxxxx	P B9997	XXX	0624XX	0701XX 0731XX	0819XX
SMITH	J	2300.95	2020.00	0901XX	37192	
xxxxxxxxx	XXXXXX	P B9997	XXX	0624XX	0801XX 0831XX	0913XX
SMITH	J	2525.00	2380.00	0927XX	37192	
PROCESS	S COMPLETED -	PLEASE COI	NTINUE			
PLEASE MAKI	E A SELECTION,	ENTER NEW KEY	DATA, PR	ESS PF3	-EXIT, PF6-SCRO	OLL FWD

9. A two-line summary of each claim's information will display. Up to five claims can display on Map 1741. You may need to use your F5 and F6 keys to scroll through the entire list of claims to find the beneficiary's claim you want to adjust. To select the claim, press your Tab key until your cursor moves under the SEL field and is to the left of the Medicare number of the claim you want to adjust.

	MAP1741		CGS J15 MAC -	- HHH REGION	ACPFA052 MM/DD/YY
	XXXXXXX	SC	CLAIM SUMMARY	' INQUIRY	C201411P HH:MM:SS
			NPI XXXXXX	XXXXX	
	MID X	XXXXXXXXX	PROVIDER	S/LOC P	TOB XX
	OPERATOR I	D XXXXXXX	FROM DATE	TO DATE	DDE SORT
	MEDICAL RE	EVIEW SELECT	DCN		
	MID	PF	ROV/MRN S/LOC	TOB ADM DT	FRM DT THRU DT REC DT
	SEL LAST N	NAME FIRST	INIT TOT CHG	PROV REIMB PD DT	CAN DT REAS NPC #DAYS
	x <b>x</b> xxxxxx	XXXXXXX	Р В999	<b>97</b> XXX 0624XX	0624XX 0630XX 0720XX
$\setminus$	SMITH		J 839.40	432.00 0816XX	37192

10. Type an *S* in the **SEL** field and press Enter. You can only select one claim at a time. After you press Enter, Page 01 (Map 1711) of the claim appears.

- → If no information appears when the claim is selected, look for a message at the bottom of the page that states "ADJUSTMENT CLAIM IS ALREADY CANCELED". When this occurs, the claim cannot be adjusted; instead, a new claim should be resubmitted to Medicare with the changed information.
  - Once the claim is selected, the third digit of the type of bill will automatically change to a 7 to signify that this is an adjustment claim. The status/location will display S B0100 identifying the adjustment as a new claim record to be processed. In addition, the Document Control Number (DCN) will be inserted automatically by the system on Page 01 of the adjustment.
- → If you are wanting to submit a Reopening, the third digit of the type of bill must be changed to a Q. Refer to the "Reopenings" Web page at <a href="http://www.cgsmedicare.com/hhh/appeals/Reopenings.html">http://www.cgsmedicare.com/hhh/appeals/Reopenings.html</a> on the CGS website for additional information about reopenings.



- 11. Adjustments are a four-step process. You must:
  - 1) Enter a Claim Change Reason Code on Page 01 of the claim;
  - 2) Enter an Adjustment Reason Code on Page 03 of the claim:
  - Make your adjustment on the applicable page(s) and add remarks on Page 04 of the claim, if necessary; and

**NOTE:** If you are adjusting a rejected claim, your charges have been moved to the noncovered charge field. As a result, you must also delete and re-enter each revenue code line so that the charges are in the

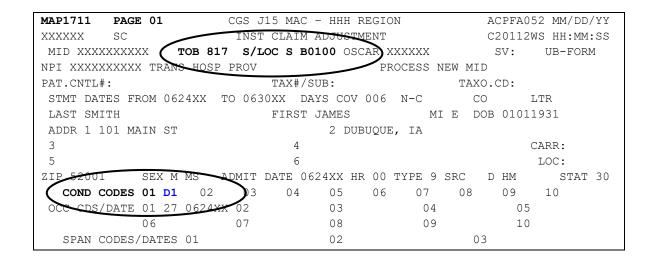
covered charge column before pressing F9. Please see the "Deleting Revenue Code Lines" and "Adding Revenue Code Lines" instructions earlier in this chapter.

4) Press *F9* to submit the adjustment.

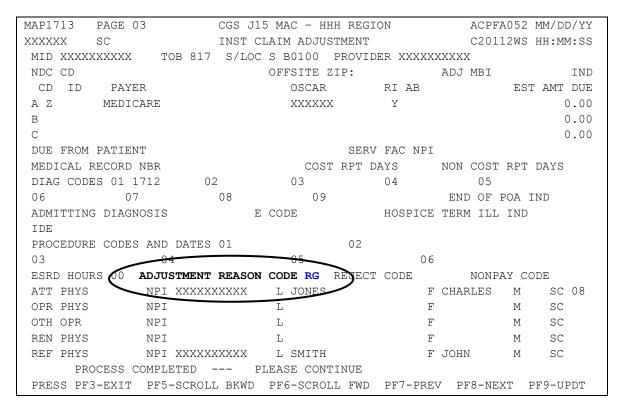
The following provides more details of this four-step process.

1. Enter the Claim Change Reason Code in the first available COND CODES field on Page 01 of the claim. Choose the one code that best describes the adjustment request. Only one is allowed per claim. If you are making multiple changes, use claim change reason code D9. If you use D9, you must include remarks on Page 04 of the claim that explains what type of changes are being made to the claim. Valid claim change reason codes are:

Claim Change Reason Code	Description
D0	Change in Service Dates (do not use for adjusting line item dates of services, use D9 instead)
D1	Change in Charges (do not use for adjusting units, use D9 instead)
D2	Change in Revenue Codes/HCPCS/HIPPS (use D9 to change a revenue code or HCPCS)
D7	Change to make Medicare secondary
D8	Change to make Medicare primary
D9	Any other change or multiple changes (requires remarks)
E0	Change in patient status



2. Enter the Adjustment Reason Code on Page 03 of the claim in the ADJUSTMENT REASON CODE field. The Adjustment Reason Code that you select should match the Claim Change Reason in terms of description. For example, if using D1 (change in charges) as the Claim Change Reason Code, use RG as the Adjustment Reason Code.



The most common adjustment reason codes are:

Adjustment Reason Codes	Description
RF	Changes in Service Dates (use with Claim Change Reason Code D0)
RG	Change in Charges (use with Claim Change Reason Code D1)
RH	Change in Revenue Codes/HCPCS/HIPPS (use with Claim Change Reason Code D2)
RM	Any other change (requires remarks) (use with Claim Change Reason Code D9)
RN	Change in patient status (use with Claim Change Reason Code E0)

# Home Health & Hospice FISS Direct Data Entry Guide

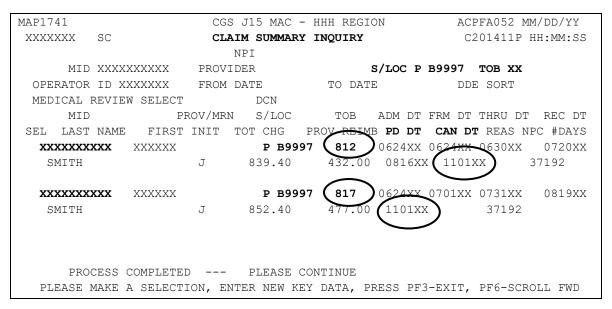
You can inquire about additional Adjustment Reason Codes by typing 16 in the **SC** field on any of the FISS claim pages and pressing *Enter*. Refer to the "Chapter 3 - Inquiry Menu"

(<a href="http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter\_3-inquiry\_menu.pdf">http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter\_3-inquiry\_menu.pdf</a>) section for information about the Adjustment Reason Codes (option 16).

- → The Adjustment Reason Code field is only a 2-digit field. If a code already appears in this field, type the appropriate Adjustment Reason Code over the existing code.
- Make your adjustment on the applicable page(s). If you are using Claim Change Reason Code D9, you must include information in the REMARKS field on Page 04 of the claim that explains what type of changes are being made to the claim.
- → When adjusting a rejected claim, please be aware that FISS places charges into the noncovered (NCOV CHARGE) field on Page 02 of the claim. Therefore, providers must first delete all revenue lines containing noncovered charges and re-enter the revenue code information in new detail lines. This will allow charges to only appear in the TOT CHARGE field. Please see the "Deleting Revenue Code Lines" and "Adding Revenue Code Lines" instructions earlier in this chapter.
- → We suggest that you enter comments in the REMARKS field for all of your adjustments. Comments are often helpful in determining what is being adjusted and why.
- 4. **Press F9**. If the system automatically takes you back to Map 1741, you have successfully submitted the adjustment for processing. Select the next claim to adjust or press F3 to return to the Claims Correction menu.
  - If you press F9 and are not returned to Map 1741, one or more errors exist. Press F1 to see the narrative for the reason code that displays in the lower left corner of the screen. When you have finished reviewing the narrative, press F3 one time to return to the claim. Make your correction and press F9. If another reason code displays, repeat this process (F1, F3, F9) until you are returned to Map 1741.
- → More than one reason code may appear at the bottom of your screen. Pressing F1 displays the narrative to the first reason code. You should correct the reason codes one at a time. Sometimes, by correcting the first code, other related codes will also be corrected. Sometimes, new codes will appear. Continue to work through the reason codes until you are returned to Map 1741. If you are having difficulty adjusting a claim, contact a Customer

Service Representative (CSR) at the telephone number listed on the Home Health & Hospice Contact Information Web page at <a href="http://www.cgsmedicare.com/hhh/cs/telephone\_numbers.html">http://www.cgsmedicare.com/hhh/cs/telephone\_numbers.html</a> on the CGS website.

→ The original paid or rejected claim will remain in FISS. After the adjustment is processed, both original claim and the adjusted claim will appear when viewing the claims in option 12, from the Inquiry Menu. See the example below. The original claim is an 812 type of bill and the adjustment is listed as an 817. In addition, the CAN DT of the original claim will match the PD DT of the adjusted (817) claim.

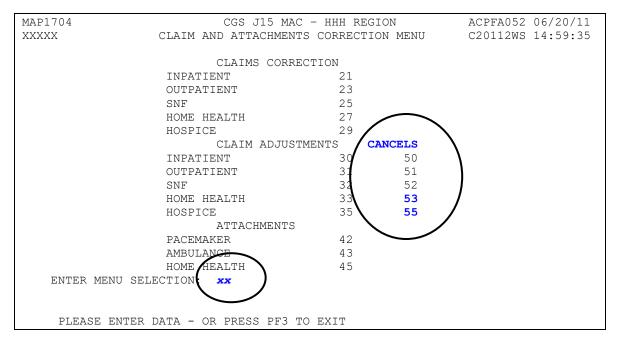


→ If your adjustment is related to a Medicare Secondary Payer situation, in FISS DDE, Claim Adjustment Segment (CAS) information must be submitted. Access the "MSP Payment Information" screen (MAP1719) by pressing F11 from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing F6 to display the "MSP Payment Information" screen for "Primary Payer 2." See the "Medicare Secondary Payer Billing and Adjustments" (<a href="http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP\_Billing.pdf">http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP\_Billing.pdf</a>) claims and Adjustments" Web page at <a href="http://www.cgsmedicare.com/hhh/education/materials/submitting\_msp.html">http://www.cgsmedicare.com/hhh/education/materials/submitting\_msp.html</a> for assistance with submitting MSP claims.

#### Canceling a Claim/RAP

Claim cancellations can only be made to paid claims/RAPs (i.e., status/location P B9997). If a claim is partially denied, a cancellation cannot be done. Providers should also not attempt to cancel RAPs/claims that are rejected (S/LOC R B9997) and do not overlap the dates of service of a beneficiary's inpatient stay, claims that are rejected, or fully denied claims (S/LOC D B9997).

- → Medicare timely filing requirements apply to claim adjustments. Refer to the Medicare Claims Processing Manual, (CMS Pub. 100-04) Ch. 1, §70.5, at <a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf">http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf</a> for additional information. In addition, refer to the "Timely Claim Filing Requirements" (<a href="http://www.cgsmedicare.com/hhh/education/materials/timely\_claim\_filing\_req.html">http://www.cgsmedicare.com/hhh/education/materials/timely\_claim\_filing\_req.html</a>) CGS Web page.
- 1. To cancel paid claims/RAPs, enter the Claim Cancels option (53 or 55) that matches your provider type and press *Enter*.



2. The Claim Summary Inquiry screen (Map 1741) appears.

MAP1741		CGS	J15 MAC	- HHH REG	ION	ACPFA052 M	M/DD/YY
XXXXXX SO	C	CLAIM	SUMMARY	INQUIRY		C20112WS H	H:MM:SS
		NE	PI				
MID		PROVIDE	ER	:	S/LOC E	TOB XX	
OPERATOR :	ID XXXXXX	FROM DA	ATE	TO DATE	E	DDE SORT	
MEDICAL R	EVIEW SELECT		DCN				
MID	PR	OV/MRN	S/LOC	TOB	ADM DI	FRM DT THRU DT	REC DT
SEL LAST	NAME FIRST	INIT TO	OT CHG	PROV REIM	B PD DI	CAN DT REAS NP	C #DAYS
PRO	OCESS COMPLET	ED 1	10 MORE I	DATA THIS ?	TYPE		
PLEAS	SE MAKE A SEL	ECTION,	ENTER NE	EW KEY DATA	A, OR E	PRESS PF3 TO EXIT	

- Type your NPI in the NPI field. To move the cursor to the NPI (National Provider Identifier) field, hold down the Shift key and press the Tab key. Your cursor will automatically move to the NPI field.
- 4. After typing your NPI, the cursor will move to the **MID** field. Type the beneficiary's Medicare number.
- 5. Tab to the **S/LOC** field and type *B9997* after the P.
- → The S/LOC field defaults to P. Because you are accessing MAP 1741 from the Claim Cancels option, only claims/RAPs in a P (Paid) status/location will be displayed. Unless you need to cancel a RAP that rejected due to overlapping an inpatient stay, only paid (P B9997) claims/RAPs are appropriate to cancel. If you need to select a rejected RAP, type an R over the top of the P that defaults in the S/LOC field and enter B9997 in the LOC field.
- 6. The **TOB** field automatically displays the first two digits of the default type of bill (TOB) based on the cancel option that you selected. If you need to cancel a claim with a different type of bill, you will need to change the default TOB, or you may remove the values from the TOB field to search claims with all TOBs. The table below identifies the claim cancel options and the default TOB:

Claim Cancels Option	Default TOB
53	33
55	81

→ Please note that effective for home health episodes beginning on or after October 1, 2013, the 33X TOB was discontinued.

7. You may also enter a From Date and To Date, but that is optional.

MAP1741			CGS	J15 MAC ·	- HHH REGI	ON		AC:	PFA052	MM/DD,	/YY
XXXXXX	SC		CLAIM	SUMMARY	INQUIRY			C2	0112WS	HH:MM	:SS
			N	PI XXXXX	XXXXX						
MI	CXXXXXX C	XXXXX	PROVID	ER		s/Loc	P		TOB XX		
OPERATO	R ID XXX	XXXX	FROM D	ATE	TO DAT	E		DDE	SORT		
MEDICAL	REVIEW	SELECT		DCN							
MI	)	PR	OV/MRN	S/LOC	TOB	ADM	DT F	RM DT '	THRU D	REC	DT
SEL LAS'	r name	FIRST	INIT T	OT CHG	PROV REIM	B PD	DT	CAN DT	REAS N	IPC #DZ	AYS

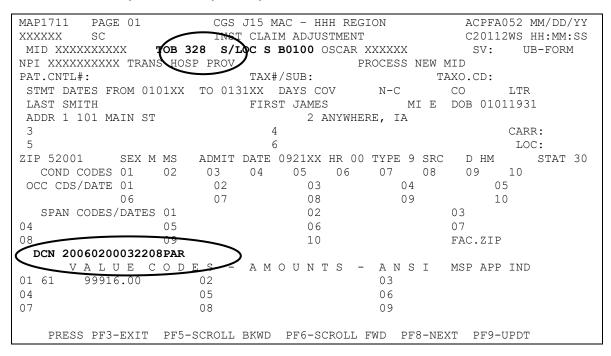
8. Press *Enter*. Any claims/RAPs matching the criteria you entered (MID, S/LOC, TOB, and/or FROM/TO DATE fields) will appear.

MAP1741		CGS J15 MAC -	HHH REGION	ACPFA052 MM/DD/YY
XXXXXXX	SC	CLAIM SUMMARY	INQUIRY	C201411P HH:MM:SS
		NPI		
MID	XXXXXXXXX	PROVIDER	S/LOC P	TOB
OPERATOR	ID XXXXXXX	FROM DATE	TO DATE	DDE SORT
MEDICAL 1	REVIEW SELECT	DCN		
MID	P.	ROV/MRN S/LOC	TOB ADM DT	FRM DT THRU DT REC DT
SEL LAST	NAME FIRST	INIT TOT CHG	PROV REIMB PD DT	CAN DT REAS NPC #DAYS
xxxxxxx	XXX XXXXXX	Р В999	<b>7 (322)</b> 0624XX	0624XX 0624XX 0629XX
SMITH		J 839.40	1520.00 1101X	x 37192
XXXXXXX	XXX XXXXXX	Р В999	<b>7 ( 322 )</b> 0624XX	0823XX 0823XX 0831XX
SMITH		J 852.40	1380.00 0904X	x 37192
PRO	CESS COMPLETE	D PLEASE C	CONTINUE	
PLEASE I	MAKE A SELECT	ION, ENTER NEW KE	Y DATA, PRESS PF	3-EXIT, PF6-SCROLL FWD

9. A two-line summary of each claim's information will display. Up to five claims can display on Map 1741. You may need to use your F5 and F6 keys to scroll through the entire list of paid claims for this particular beneficiary. To select a claim, press your Tab key until your cursor moves under the SEL field and is to the left of the Medicare number of the claim/RAP you want to cancel.

MAP1741		CGS J15 MAC	- HHH REGION	ACPFA052 MM/DD/YY
XXXXXX SC		CLAIM SUMMARY	INQUIRY	C20112WS HH:MM:SS
		NPI XXXXX	XXXXX	
MID XX	XXXXXXXX	PROVIDER	S/LOC P	TOB
OPERATOR II	XXXXXX	FROM DATE	TO DATE	DDE SORT
MEDICAL REV	'IEW SELECT	DCN		
MID	PF	ROV/MRN S/LOC	TOB ADM DT	FRM DT THRU DT REC DT
SEL LAST NA	ME FIRST	INIT TOT CHG	PROV REIMB <b>PD DT</b>	CAN DT REAS NPC #DAYS
S xxxxxxxxx	<b>X</b> XXXXX	Р В99	<b>997 322</b> 0624XX	0624XX 0624XX 0629XX
SMITH		J 839.40	1520.00 1101XX	37192

- → Occasionally, the Common Working File will automatically adjust claims. CGS may also initiate claim adjustments. These types of adjustments are identified with a "G", or "I" as the third digit of the type of bill (TOB) (e.g., 3XG, 3XI). A cancel should not be made to an adjustment initiated by CGS or CWF. Instead, an adjustment should be submitted if the 3XG or 3XI claim has finalized in FISS status/location P B9997 or R B9997, and the claim information needs to be modified (i.e., remove visits, add charges, etc.). See the instructions in the "Adjusting Claims" section, found in this chapter, for submitting Medicare adjustments using FISS.
- 10. Type an S in the SEL field and press Enter. You can only select one claim at a time. After you press Enter, Page 01 (Map 1711) of the claim appears. The type of bill will automatically change the third digit to an 8 to signify that this is a cancel claim. In addition, the Document Control Number (DCN) will be automatically inserted by the system.



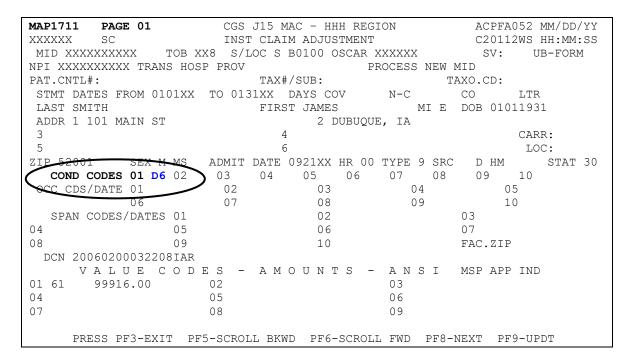
Cancellations are a three-step process. You must:

- 1) Enter a Claim Change Reason Code on Page 01 of the claim;
- 2) Enter an Adjustment Reason Code on Page 03 of the claim; and
- 3) Press F9 to submit the cancellation.

The following provides more details of this three-step process.

1. Enter the Claim Change Reason Code in the first available COND CODES field on Page 01 of the claim. Only one code is allowed per claim. Valid claim change reason codes for cancellations are:

Claim Change Reason Code	Description
D5	Cancel only to correct Medicare number or provider number
D6	Cancel only to repay duplicate payment or correct error (all other reasons)



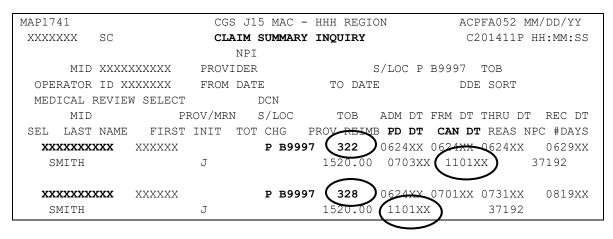
2. Enter the Adjustment Reason Code on Page 03 of the claim in the ADJUSTMENT REASON CODE field. The Adjustment Reason Code that you select should match the Claim Change Reason in terms of description. For example, if using D5 (cancel to correct Medicare number or provider number) as the Claim Change Reason Code, use RI as the Adjustment Reason Code. The most common adjustment reason codes for cancellations are:

Adjustment Reason Codes
RI — Cancel to correct Medicare number or provider number
RJ — Cancel duplicate or OIG overpayment (all other reasons)

You can access additional Adjustment Reason Codes by typing 16 in the **SC** field on any of the FISS claim pages and pressing *Enter*.

→ The Adjustment Reason Code is only a 2-digit field. If a code already appears in this field, type the appropriate Adjustment Reason Code over the existing code.

- 3. **Press F9**. If the system automatically takes you back to Map 1741, you have successfully submitted the cancellation for processing. Select the next claim to cancel or press F3 to return to the Claims Correction menu.
  - If you press F9 and are not returned to Map 1741 automatically, one or more errors exist. Press *F1* to see the narrative for the reason code that displays in the lower left corner of the screen. When you have finished reviewing the narrative, press *F3* one time to return to the claim. Make your correction and press *F9*. Repeat this process (F1, F3, F9) until you are returned to Map 1741.
- → More than one reason code may appear at the bottom of your screen. Pressing F1 displays the first reason code. You should correct the reason codes one at a time. Sometimes, by correcting the first code, other related codes will also be corrected. Sometimes, new codes will appear. Continue to work through the reason codes until you are returned to Map 1741. If you are having difficulty cancelling a claim, contact a Customer Service Representative (CSR) at the telephone number listed on our Web site at: <a href="https://cgsmedicare.com/hhh/cs/cs">https://cgsmedicare.com/hhh/cs/cs</a> phone fax.html
- → The original paid claim, or paid or rejected RAP, will remain in FISS. After the cancel is processed, both the original claim and the cancelled claim will appear when viewing the claims in option 12, from the Inquiry Menu. See the example below. The original claim is a 322 type of bill and the cancellation is listed as a 328. In addition, the CAN DT of the original claim/RAP will match the PD DT of the cancel (328) claim/RAP.

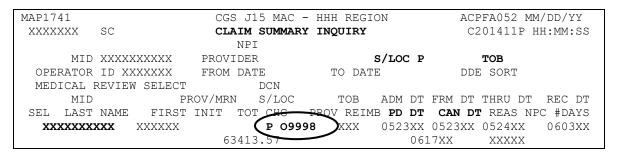


→ To avoid billing errors, ensure that the "cancel" RAP/claim (XX8 type of bill) is in FISS S/LOC P B9997 prior to submitting a new RAP/claim with the corrected information.

#### **Archived Claims**

FISS will archive claim data on processed claims after 18 months from the date the claim is processed. Because the timely filing requirement is one calendar year after the date of service, adjustments or claim cancellations should not be done after a claim has been archived. However, FISS allows the ability for you to retrieve an archived claim to inquire into how it was submitted and processed.

Archived claims can be identified by status/location P O9998 or R O9998. Please note that the location begins with the letter "O" as in "offline" and not a "O" (zero). These claims can be accessed by selecting 12 (Claims) from the Inquiry Menu; type your NPI in the **NPI** field, type the beneficiary's Medicare number in the **MID** field. Then tab to the **S/LOC** field and enter *P O9998* or *R O9998*. Press *Enter*. Archived claims do not display the beneficiary's name or the provider reimbursement amount.



1. To retrieve an archived claim, access the Claim and Attachments Correction Menu (option 03 from the FISS Maim Menu), then access either the Claims Adjustment options 33 or 35 or Claims Cancel options 53 or 55. Follow the instructions outlined earlier in this section for accessing the billing transaction you want to view. Type an S in the SEL field and press Enter. After you press Enter, Page 01 (Map 1711) of the claim displays; however, because the claim data is archived, all claim pages appear blank. The message "ADJUSTMENT CLAIM IS PRESENTLY OFFLINE PF10 TO RETRIEVE" will display.



2. Press the F10 key. FISS will retrieve the claim data from the archive. This is done during the weekly system cycle. Therefore, the claim information for which the retrieval was requested will appear the following Monday in status/location P B9997 (if claim was originally paid), or R B9997 (if claim was originally rejected). At that time, you are able to view the claim data.