

Home Health & Hospice

Claims Correction

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

Chapter 5



A CELERIAN GROUP COMPANY



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CGS

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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.

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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*.

```
MAP1701                CGS J15 MAC - HHH REGION        ACPFA052 MM/DD/YY
XXXXXX                MAIN MENU                    C20112WS HH:MM:SS

01    INQUIRIES
02    CLAIMS/ATTACHMENTS
03    CLAIMS CORRECTION
04    ONLINE REPORTS

ENTER MENU SELECTION: 03

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

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

```

MAP1704          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXX          CLAIM AND ATTACHMENTS CORRECTION MENU      C20112WS HH:MM:SS

          CLAIMS CORRECTION
INPATIENT                21
OUTPATIENT               23
SNF                      25
HOME HEALTH              27
HOSPICE                  29
          CLAIM ADJUSTMENTS          CANCELS
INPATIENT                30          50
OUTPATIENT               31          51
SNF                      32          52
HOME HEALTH              33          53
HOSPICE                  35          55
          ATTACHMENTS
PACEMAKER                42
AMBULANCE                43
HOME HEALTH              45
ENTER MENU SELECTION: XX

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
    
```

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.

1. 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.
2. 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 (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R116MSP.pdf>) 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” (http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf) 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. Your cursor will automatically move to the NPI field.

➔ Only the claims for the NPI entered will appear.

MAP1741	CGS J15 MAC - HHH REGION	ACPFA052 MM/DD/YY
XXXXXX SC	CLAIM SUMMARY INQUIRY	C20112WS HH:MM:SS
	NPI XXXXXXXXXXXX	
MID	PROVIDER	S/LOC T B9997 TOB XX
OPERATOR ID XXXXXX	FROM DATE	TO DATE
MEDICAL REVIEW SELECT	DCN	DDE SORT
MID	PROV/MRN	S/LOC
SEL LAST NAME	FIRST INIT	TOT CHG
	PROV REIMB	PD DT
	CAN DT	REAS NPC #DAYS

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD

➔ 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.

4. 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
H	Medicare number
M	Medical Record Number
N	Last Name
R	Reason Code

```

MAP1741          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX   SC          CLAIM SUMMARY INQUIRY          C20112WS HH:MM:SS
                   NPI XXXXXXXXXXXX
                   MID          PROVIDER          S/LOC T B9997 TOB XX
OPERATOR ID XXXXXX FROM DATE          TO DATE          DDE SORT H
MEDICAL REVIEW SELECT          DCN
                   MID          PROV/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
    
```

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 XXXXXX SC	CGS J15 MAC - HHH REGION CLAIM SUMMARY INQUIRY NPI XXXXXXXXXXXX		ACPFA052 MM/DD/YY C20112WS HH:MM:SS	
MID OPERATOR ID XXXXXX	PROVIDER FROM DATE	S/LOC T B9997	TOB XX	DDE SORT H
MEDICAL REVIEW SELECT	DCN			
MID SEL LAST NAME	PROV/MRN FIRST INIT	S/LOC TOT CHG	TOB PROV REIMB	ADM DT FRM DT THRU DT REC DT PD DT CAN DT REAS NPC #DAYS
XXXXXXXXXX	XXXXXX	T B9997	XXX	0921XX 0101XX 0131XX 0215XX
SMITH	J	272.94		0216XX 37402 11
XXXXXXXXXX	XXXXXX	T B9997	XXX	0726XX 0801XX 0805XX 0215XX
JONES	S	975.00		0831XX 37402 06
XXXXXXXXXX	XXXXXX	T B9997	XXX	0803XX 0803XX 0806XX 0215XX
DOE	J	1250.00		0920XX 37402 10

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” (http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf) 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 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX   SC          CLAIM SUMMARY INQUIRY          C20112WS HH:MM:SS
                    NPI XXXXXXXXXXXX

MID              PROVIDER          S/LOC T B9997 TOB XX
OPERATOR ID XXXXX FROM DATE        TO DATE        DDE SORT
MEDICAL REVIEW SELECT          DCN

MID              PROV/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
-  XXXXXXXXXXXX  XXXXXXX  T B9997  XXX  0921XX 0101XX 0131XX  0215XX
SMITH            J            272.94          0216XX          37402    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 XXXXXXXXXXXX  TOB XXX  S/LOC S B0100 OSCAR XXXXXXX  SV:  UB-FORM
NPI XXXXXXXXXXXX TRANS HOSP PROV          PROCESS NEW MID
PAT.CNTL#:          TAX#/SUB:          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 SRC  D HM          STAT 30
COND CODES 01      02      03      04      05      06      07      08      09      10
OCC CDS/DATE 01          02          03          04          05
06          07          08          09          10
SPAN CODES/DATES 01          02          03
04          05          06          07
08          09          10          FAC.ZIP
DCN
V A L U E  C O D E S  -  A M O U N T S  -  A N S I  MSP APP IND
01 61      99916.00          02          03
04          05          06
07          08          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 <http://www.cgsmedicare.com/hhh/education/materials/cses.html> on the CGS website.


```

MAP1881                CGS J15 MAC - HHH REGION                ACPFA052 MM/DD/YY
XXXXXX   SC                REASON CODES INQUIRY                C20112WS HH:MM:SS
                                                MNT: CMSSTD   XXXXXX
PLAN REAS  NARR   EFF      MSN      EFF      TERM      EMC      HC/PRO  PP   CC
IND  CODE  TYPE   DATE      REAS      DATE      DATE      ST/LOC  ST/LOC  LOC  IND
  1  37402   E    080100
  TPTP A    B    NPCD A    B    HD CPY A    B    NB ADR    CAL DY    C/L C
-----NARRATIVE-----
THIS IS A HOSPICE CLAIM AND THE CLAIM RECEIPT DATE IS GREATER THAN OR EQUAL
TO 10/01/05 AND THERE IS NO CLAIM PENDING OR FINALIZED WITH A THROUGH DATE
ONE DAY LESS THAN THIS CLAIM'S FROM DATE.
**
YOU MUST ENSURE THAT THE CURRENT BILL TYPE IS EQUAL TO THE HISTORY BILL
TYPE.  IF THE HISTORY BILL IS AN 81X, THEN THE CURRENT BILL TYPE MUST BE AN
81X AND AN 82X MUST EQUAL A HISTORY 82X.

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PRESS PF3-EXIT PF6-SCROLL FWD PF8-NEXT
    
```

9. Once you have reviewed the narrative, press *F3* one time to return to the claim. Make the correction and press *F9*. 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 *F3* to return to the Claims Correction and Attachments Menu.

If you press *F9* and are not returned to Map 1741 automatically, one or more errors still exist. Press *F1* again to see the narrative for the next reason code. 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 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.html) CGS Web page.

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

MAP1741	CGS J15 MAC - HHH REGION				ACPFA052 MM/DD/YY				
XXXXXX	SC	CLAIM SUMMARY INQUIRY				C20112WS 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	PROV/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 N/C	#DAYS	
	XXXXXXXXXX	XXXXXX		T B9997	XXX	0921XX	0101CC	0131XX	0215XX
	SMITH	J	272.94			0216XX		37402	11

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.
2. 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**.

MAP1711	PAGE 01	CGS J15 MAC - HHH REGION	ACPFA052 MM/DD/YY
XXXXXX	SC	INST CLAIM UPDATE	C20112WS HH:MM:SS
MID XXXXXXXXXXX	TOB 813	S/LOC S B0100 OSCAR XXXXXX	SV: UB-FORM
NPI XXXXXXXXXXX	TRANS HOSP PROV	PROCESS NEW MID Y XXXXXXXXXXXB	
PAT.CNTL#:	TAX#/SUB:	TAXO CD:	
STMT DATES FROM 0101XX	TO 0131XX	DAYS COV	N-C CO LTR

➔ 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	CGS J15 MAC - HHH REGION	ACPFA052	MM/DD/YY								
XXXXXX	SC	INST CLAIM UPDATE	C20112WS	HH:MM:SS								
			REV CD	PAGE 01								
MID	XXXXXXXXXX	TOB XXX	S/LOC S	B9997	PROVIDER	XXXXXXXXXX						
UTN		PROG	REP	PAYEE	RRB	EXCL IND	PROV	VAL	TYPE			
			TOT	COV					SERV	RED		
CL	REV	HCPC	MODIFS	RATE	UNIT	UNIT	TOT	CHARGE	NCOV	CHARGE	DATE	IND
1	0023	2AGL1			00060	00060					0215XX	
2	0270							50.00			0215XX	
3	0551	G0299		104.910	00002	00002		100.00			0222XX	
4	D 551	G0299		104.910	00004	00004		100.00			0229XX	
5	0001							250.00				

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 J15 MAC - HHH REGION	ACPFA052 MM/DD/YY
XXXXXX	SC	INST CLAIM UPDATE	C20112WS HH:MM:SS
			REV CD PAGE 01
MID XXXXXXXXXXX	TOB XXX	S/LOC S B9997	PROVIDER XXXXXXXXXXX
UTN	PROG	REP PAYEE	RRB EXCL IND
		TOT COV	PROV VAL TYPE
CL	REV	HCPC MODIFS	RATE UNIT UNIT
			TOT CHARGE NCOV CHARGE
			SERV DATE
			RED IND
1	0023	2AGL1	00060 00060
2	0270		50.00
3	0551	G0299	104.910 00002 00002
4	0551	G0299	104.910 00004 00004
5	0001		350.00
6	0551	G0300	00003 00003
			100.00
			0215XX
			0215XX
			0222XX
			0229XX
			0217XX
PROCESS COMPLETED --- PLEASE CONTINUE			
PRESS PF2-171D PF3-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.

MAP1711	PAGE 01	CGS J15 MAC - HHH REGION	ACPFA052 MM/DD/YY
XXXXXX	SC	INST CLAIM UPDATE	C20112WS HH:MM:SS
MID XXXXXXXXXXXX	TOB XXX	S/LOC S B0100 OSCAR XXXXXX	SV: Y UB-FORM
NPI XXXXXXXXXXXX	TRANS HOSP PROV	PROCESS NEW MID	
PAT.CNTL#:	TAX#/SUB:	TAXO.CD:	
STMT DATES FROM 0101XX	TO 0131XX	DAYS COV	N-C CO LTR

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” (http://www.cgsmedicare.com/hhh/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/Cancel” Web page at http://www.cgsmedicare.com/hhh/education/materials/Adjustments_Cancel.html 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 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf> for additional information. In addition, refer to the “Timely Claim Filing Requirements” (http://www.cgsmedicare.com/hhh/education/materials/timely_claim_filing_req.html) 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” (http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf) 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*.

```
MAP1704          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX          CLAIM AND ATTACHMENTS CORRECTION MENU      C20112WS HH:MM:SS

                CLAIMS CORRECTION
                INPATIENT                21
                OUTPATIENT              23
                SNF                      25
                HOME HEALTH             27
                HOSPICE                  29

                CLAIM ADJUSTMENTS        CANCELS
                INPATIENT                30          50
                OUTPATIENT              31          51
                SNF                      32          52
                HOME HEALTH             33          53
                HOSPICE                  35          55

                ATTACHMENTS
                PACEMAKER                42
                AMBULANCE                43
                HOME HEALTH              45

ENTER MENU SELECTION XX

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

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 INQUIRY          C20112WS HH:MM:SS
                   NPI
                   MID          PROVIDER          S/LOC P          TOB XX
OPERATOR ID XXXXXX FROM DATE          TO DATE          DDE SORT
MEDICAL REVIEW SELECT          DCN
                   MID          PROV/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 EXIT
PRESS PF3-EXIT PF5-SCROLL 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 - HHH REGION          ACPFA052 MM/DD/YY
XXXXXXXX SC          CLAIM SUMMARY INQUIRY          C201411P HH:MM:SS
                   NPI XXXXXXXXXXXX

      MID XXXXXXXXXXX PROVIDER          S/LOC P          TOB XX
OPERATOR ID XXXXXXX FROM DATE          TO DATE          DDE SORT
MEDICAL REVIEW SELECT          DCN

      MID          PROV/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
XXXXXXXXXX  XXXXXX          P B9997  XXX  0624XX 0624XX 0630XX  0720XX
SMITH          J          839.40  432.00  0816XX          37192

XXXXXXXXXX  XXXXXX          P B9997  XXX  0624XX 0701XX 0731XX  0819XX
SMITH          J          2300.95  2020.00  0901XX          37192

XXXXXXXXXX  XXXXXX          P B9997  XXX  0624XX 0801XX 0831XX  0913XX
SMITH          J          2525.00  2380.00  0927XX          37192

PROCESS COMPLETED --- PLEASE CONTINUE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-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 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
XXXXXXXX SC          CLAIM SUMMARY INQUIRY          C201411P HH:MM:SS
                   NPI XXXXXXXXXXXX

      MID XXXXXXXXXXX PROVIDER          S/LOC P          TOB XX
OPERATOR ID XXXXXXX FROM DATE          TO DATE          DDE SORT
MEDICAL REVIEW SELECT          DCN

      MID          PROV/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
— XXXXXXXXX  XXXXXX          P B9997  XXX  0624XX 0624XX 0630XX  0720XX
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 <http://www.cgsmedicare.com/hhh/appeals/Reopenings.html> on the CGS website for additional information about reopenings.

MAP1711	PAGE 01	CGS J15 MAC - HHH REGION	ACPFA052 MM/DD/YY
XXXXXX	SC	INST CLAIM ADJUSTMENT	C20112WS HH:MM:SS
MID XXXXXXXXXXXX	TOB 817	S/LOC S B0100 OSCAR XXXXXX	SV: UB-FORM
NPI XXXXXXXXXXXX	TRANS HOSP PROV	PROCESS NEW MID	
PAT.CNTL#:	TAX#/SUB:	TAXO.CD:	
STMT DATES FROM 0624XX	TO 0630XX	DAYS COV 006	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 0624XX	HR 00 TYPE 9 SRC D HM STAT 30
COND CODES 01	02	03	04 05 06 07 08 09 10
OCC CDS/DATE 01 27	0624XX	02	03 04 05 06 07 08 09 10
SPAN CODES/DATES 01		02	03 04 05 06 07 08 09 10
DCN 20060200032208PAR			
V A L U E C O D E S	-	A M O U N T S	-
A N S I		M S P	A P P I N D
01 61	99916.00	02	03
04		05	06

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;
- 3) 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

```

MAP1711  PAGE 01          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX  SC              INST CLAIM ADJUSTMENT          C20112WS HH:MM:SS
MID XXXXXXXXXXXX  TOB 817  S/LOC S B0100 OSCAR XXXXXX  SV:  UB-FORM
NPI XXXXXXXXXXXX TRANS HOSP PROV          PROCESS NEW MID
PAT.CNTL#:          TAX#/SUB:          TAXO.CD:
STMT DATES FROM 0624XX TO 0630XX  DAYS COV 006  N-C          CO          LTR
LAST SMITH          FIRST JAMES          MI E  DOB 01011931
ADDR 1 101 MAIN ST          2 DUBUQUE, IA
3                      4                      CARR:
5                      6                      LOC:
ZIP 52001          SEX M MS          ADMIT DATE 0624XX HR 00 TYPE 9 SRC  D HM          STAT 30
COND CODES 01 D1  02  03  04  05  06  07  08  09  10
OCC CDS/DATE 01 27 0624XX 02          03          04          05
          06          07          08          09          10
SPAN CODES/DATES 01          02          03
    
```

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.

```

MAP1713 PAGE 03 CGS J15 MAC - HHH REGION ACPFA052 MM/DD/YY
XXXXXX SC INST CLAIM ADJUSTMENT C20112WS HH:MM:SS
MID XXXXXXXXXXXX TOB 817 S/LOC S B0100 PROVIDER XXXXXXXXXXXX
NDC CD OFFSITE ZIP: ADJ MBI IND
CD ID PAYER OSCAR RI AB EST AMT DUE
A Z MEDICARE XXXXXX Y 0.00
B 0.00
C 0.00
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAG CODES 01 1712 02 03 04 05
06 07 08 09 END OF POA IND
ADMITTING DIAGNOSIS E CODE HOSPICE TERM ILL IND
IDE
PROCEDURE CODES AND DATES 01 02
03 04 05 06
ESRD HOURS 00 ADJUSTMENT REASON CODE RG REJECT CODE NONPAY CODE
ATT PHYS NPI XXXXXXXXXXXX L JONES F CHARLES M SC 08
OPR PHYS NPI L F M SC
OTH OPR NPI L F M SC
REN PHYS NPI L F M SC
REF PHYS NPI XXXXXXXXXXXX L SMITH F JOHN M SC
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-UPDT
    
```

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)

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”

(http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf) 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.
- 3. **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 http://www.cgsmedicare.com/hhh/cs/telephone_numbers.html 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.

MAP1741	CGS J15 MAC - HHH REGION		ACPPA052 MM/DD/YY	
XXXXXXXX SC	CLAIM SUMMARY INQUIRY		C201411P HH:MM:SS	
NPI				
MID XXXXXXXXXXXX	PROVIDER	S/LOC P B9997 TOB XX		
OPERATOR ID XXXXXXXX	FROM DATE	TO DATE		DDE SORT
MEDICAL REVIEW SELECT		DCN		
MID	PROV/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
XXXXXXXXXXXX	XXXXXX	P B9997	812	0624XX 0624XX 0630XX 0720XX
SMITH	J	839.40	432.00	0816XX 1101XX 37192
XXXXXXXXXXXX	XXXXXX	P B9997	817	0624XX 0701XX 0731XX 0819XX
SMITH	J	852.40	477.00	1101XX 37192
PROCESS COMPLETED --- PLEASE CONTINUE				
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD				

- ➔ 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” (http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf) quick resource tool or the “Submitting Medicare Secondary Payer (MSP) Claims and Adjustments” Web page at http://www.cgsmedicare.com/hhh/education/materials/submitting_msp.html 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 <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf> for additional information. In addition, refer to the "Timely Claim Filing Requirements" (http://www.cgsmedicare.com/hhh/education/materials/timely_claim_filing_req.html) 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*.

```
MAP1704          CGS J15 MAC - HHH REGION          ACPFA052 06/20/11
XXXXX          CLAIM AND ATTACHMENTS CORRECTION MENU      C20112WS 14:59:35

                CLAIMS CORRECTION
                INPATIENT                21
                OUTPATIENT              23
                SNF                      25
                HOME HEALTH              27
                HOSPICE                  29
                CLAIM ADJUSTMENTS        CANCELS
                INPATIENT                30          50
                OUTPATIENT              31          51
                SNF                      32          52
                HOME HEALTH              33          53
                HOSPICE                  35          55
                ATTACHMENTS
                PACEMAKER                42
                AMBULANCE                43
                HOME HEALTH              45
ENTER MENU SELECTION: xx

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```


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

MAP1741 XXXXXX SC	CGS J15 MAC - HHH REGION CLAIM SUMMARY INQUIRY NPI XXXXXXXXXXXX	ACPFA052 MM/DD/YY C20112WS HH:MM:SS
MID XXXXXXXXXXXX OPERATOR ID XXXXXX MEDICAL REVIEW SELECT	PROVIDER FROM DATE DCN	S/LOC P TO DATE DDE SORT
MID SEL LAST NAME	PROV/MRN FIRST INIT	S/LOC TOT CHG
	TOB PROV REIMB	ADM DT PD DT
	FRM DT CAN DT	THRU DT REAS NPC
	REC DT #DAYS	

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

MAP1741 XXXXXX SC	CGS J15 MAC - HHH REGION CLAIM SUMMARY INQUIRY NPI	ACPFA052 MM/DD/YY C201411P HH:MM:SS
MID XXXXXXXXXXXX OPERATOR ID XXXXXX MEDICAL REVIEW SELECT	PROVIDER FROM DATE DCN	S/LOC P TOB DDE SORT
MID SEL LAST NAME	PROV/MRN FIRST INIT	S/LOC TOT CHG
	TOB PROV REIMB	ADM DT PD DT
	FRM DT CAN DT	THRU DT REAS NPC
	REC DT #DAYS	
XXXXXXXXXX SMITH	XXXXXXXX J	P B9997 322 839.40 1520.00 1101XX 37192
XXXXXXXXXX SMITH	XXXXXXXX J	P B9997 322 852.40 1380.00 0904XX 37192
PROCESS COMPLETED --- PLEASE CONTINUE		
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-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 XXXXXX SC	CGS J15 MAC - HHH REGION CLAIM SUMMARY INQUIRY NPI XXXXXXXXXXXX	ACPFA052 MM/DD/YY C20112WS HH:MM:SS
MID XXXXXXXXXXXX OPERATOR ID XXXXXX MEDICAL REVIEW SELECT	PROVIDER FROM DATE DCN	S/LOC P TOB DDE SORT
MID SEL LAST NAME	PROV/MRN FIRST INIT	S/LOC TOT CHG
	TOB PROV REIMB	ADM DT PD DT
	FRM DT CAN DT	THRU DT REAS NPC
	REC DT #DAYS	
S XXXXXXXXXXXX SMITH	XXXXXXXX J	P B9997 322 839.40 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.

```

MAP1711 PAGE 01 CGS J15 MAC - HHH REGION ACPFA052 MM/DD/YY
XXXXXX SC INST CLAIM ADJUSTMENT C20112WS HH:MM:SS
MID XXXXXXXXXXXX TOB 328 S/LOC S B0100 OSCAR XXXXXX SV: UB-FORM
NPI XXXXXXXXXXXX TRANS HOSP PROV PROCESS NEW MID
PAT.CNTL#: TAX#/SUB: 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 SRC D HM STAT 30
COND CODES 01 02 03 04 05 06 07 08 09 10
OCC CDS/DATE 01 02 03 04 05
06 07 08 09 10
SPAN CODES/DATES 01 02 03
04 05 06 07
08 09 10 FAC.ZIP
DCN 20060200032208PAR
VALUE CODES - AMOUNTS - ANS I MSP APP IND
01 61 99916.00 02 03
04 05 06
07 08 09

PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT PF9-UPDT
    
```

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)

```

MAP1711 PAGE 01 CGS J15 MAC - HHH REGION ACPFA052 MM/DD/YY
XXXXXX SC INST CLAIM ADJUSTMENT C20112WS HH:MM:SS
MID XXXXXXXXXXXX TOB XX8 S/LOC S B0100 OSCAR XXXXXX SV: UB-FORM
NPI XXXXXXXXXXXX TRANS HOSP PROV PROCESS NEW MID
PAT.CNTL#: TAX#/SUB: 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 DUBUQUE, IA
3 4 CARR:
5 6 LOC:
ZIP 52001 SEX M MS ADMIT DATE 0921XX HR 00 TYPE 9 SRC D HM STAT 30
COND CODES 01 D6 02 03 04 05 06 07 08 09 10
OCC CDS/DATE 01 02 03 04 05
06 07 08 09 10
SPAN CODES/DATES 01 02 03
04 05 06 07
08 09 10 FAC.ZIP
DCN 20060200032208IAR
VALUE CODES - AMOUNTS - ANS I MSP APP IND
01 61 99916.00 02 03
04 05 06
07 08 09
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT PF9-UPDT
    
```

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: https://cgsmedicare.com/hhh/cs/cs_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.

MAP1741		CGS J15 MAC - HHH REGION				ACPFA052 MM/DD/YY			
XXXXXXX SC		CLAIM SUMMARY INQUIRY				C201411P HH:MM:SS			
NPI									
MID XXXXXXXXXXXX		PROVIDER			S/LOC P B9997 TOB				
OPERATOR ID XXXXXXXX		FROM DATE			TO DATE		DDE SORT		
MEDICAL REVIEW SELECT				DCN					
MID		PROV/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
	XXXXXXXXXX	XXXXXX			P B9997	322	0624XX	0624XX	0624XX
	SMITH	J			1520.00	0703XX	1101XX		37192
	XXXXXXXXXX	XXXXXX			P B9997	328	0624XX	0701XX	0731XX
	SMITH	J			1520.00	1101XX			37192

- ➔ 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 “0” (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.

MAP1741	CGS J15 MAC - HHH REGION		ACPFA052 MM/DD/YY	
XXXXXXX SC	CLAIM SUMMARY INQUIRY		C201411P HH:MM:SS	
	NPI			
MID XXXXXXXXXXXX	PROVIDER	S/LOC P	TOB	
OPERATOR ID XXXXXXXX	FROM DATE	TO DATE	DDE SORT	
MEDICAL REVIEW SELECT	DCN			
MID	PROV/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
XXXXXXXXXXXX	XXXXXX	P O9998	XXX	0523XX 0523XX 0524XX 0603XX
	63413.57		0617XX	XXXXX

- 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.

ADJUSTMENT CLAIM IS PRESENTLY OFFLINE PF10 TO RETRIEVE

- 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.