

Chapter Five – Corrections, Adjustments, Cancels, RTP Workflows

Table of Contents

CHAPTER FIVE – CLAIMS CORRECTIONS – MAP1704.....	2
General Information	3
Claim Summary Inquiry – MAP1741	3
Reason Code Inquiry – MAP1881	4

CHAPTER FIVE – CLAIMS CORRECTIONS – MAP1704

The Claims and Attachment Corrections menu, option 03 on the Main Menu, is used to access claims already in the system that need to be revised.

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MAP1704      MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT  ACMFA522 12/13/24
TXM9331      CLAIM CORRECTION MENU                    A2025100 14:39:31

                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

ENTER MENU SELECTION:

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

Corrections under the Claims Corrections section of this menu are made to claims that have been submitted, but are incomplete or contain data that fails edits, and must be returned to the provider (RTP'd).

Corrections under the Claims Adjustments and Cancel options are made to claims that have been processed and completed previously.

Options available from this menu are:

- Claims Correction
 - Inpatient – 21
 - Outpatient – 23
 - SNF – 25
 - Home Health – 27
 - Hospice – 29
- Claim Adjustment
 - Inpatient – 30
 - Outpatient – 31
 - SNF – 32
 - Home Health – 33
 - Hospice – 35
 - Cancel

- Inpatient – 50
- Outpatient – 51
- SNF – 52
- Home Health – 53
- Hospice – 55

Attachments options shown on the menu are not used.

General Information

When you select an option from the Claims and Attachment Corrections menu, the same Claims Summary Inquiry screen you would see under the Claims Inquiry menu; however, you must access it through the Corrections menu in order to make changes to claims. The system will assign edits and auto-fill certain fields appropriate to that option.

Claim Summary Inquiry – MAP1741

MID		PROVIDER		S/LOC		TOB								
OPERATOR ID	NAK3378	FROM DATE	TO DATE			DDE SORT								
MEDICAL REVIEW SELECT		DCN												
SEL	LAST NAME	FIRST	INIT	TOT	CHG	PROV	REIMB	PD	DT	CAN	DT	REAS	NPC	#DAYS
					S	M9001	212	020319	021419	021819				031219
				200.00			1620.48					U5606		
					S	M9001	211	050319	051419	051819				062719
				200.00			1296.38					U5606		
					S	MKPTD	211	010319	011419	011819				070219
				200.00			1296.38							
					S	M9001	211	080619	081419	081819				092319
				200.00			1296.38					U5606		
					T	B9997	211	080619	081419	081819				111119

Once a claim has been selected, you can view the Reason Code narrative by entering “17” in the SC field in the upper left corner of the screen, or by using the [F1] key. If you want to look up more than one reason code, simply type another code over the first and press [ENTER]. When you are ready to return to the claim, press [F3] once.

Reason Code Inquiry – MAP1881

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MAP1881          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT          090321
SC              REASON CODES INQUIRY
PLAN REAS  NARR  EFF    MSN    EFF    TERM    EMC    MNT:  HC/PRO  PP  CC
IND  CODE  TYPE  DATE    REAS    DATE    DATE    ST/LOC  ST/LOC  LOC  IND
1    17701  E    122289                T      T

TPTP A    B    NPCD A    B    HD  CPY A    B    NB  ADR    CAL  DY    C/L  C
-----NARRATIVE-----
PRINCIPAL DIAGNOSIS CODE AND ADMITTING DIAGNOSIS CODE (IF
PRESENT) MUST BE THREE TO SIX POSITIONS LEFT JUSTIFIED WITH NO
DECIMAL POINTS.  THE FOLLOWING CONDITIONS WILL BE VALIDATED BY
THE MEDICARE CODE EDITOR; ALL ERRORS MUST BE CORRECTED PRIOR TO
RUNNING THE MEDICARE GROUPER PROGRAM.
ERROR CODE      EXPLANATION
17601           INVALID DIAGNOSIS OR PROCEDURE CODE
17602           INVALID FOURTH OF FIFTH DIGIT (ICD9CM)
17603           E-CODE AS PRINCIPLE DIAGNOSIS
17604           DUPLICATE OF PRINCIPAL DIAGNOSIS
17605           AGE CONFLICTS WITH THE DIAGNOSIS
17606           SEX CONFLICTS WITH THE DIAGNOSIS
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
  
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Correcting Revenue Code Lines

When making changes to a revenue code line in either claims that have been RTP'd or claims that need to be adjusted, follow these procedures:

- To delete an entire Revenue Code line:
 - [TAB] to the line and type “D” in the first position
 - Press [HOME] to go to the Page Number field, press [ENTER]. The line will be deleted.
 - Next, add up the individual line items and correct the total charge amount on Revenue Code line 0001.
- To add a Revenue Code line:
 - [TAB] to the line below the 0001 total charge line.
 - Type the new Revenue Code information.
 - Press [HOME] to go to the Page Number field, press [ENTER]. The system will re-sort the Revenue Codes into numerical order.
 - Correct the total charge amount of line 0001.
- Changing total and non-covered charge amounts:
 - [TAB] to get to the beginning of the total charge field on a line item.
 - Press [END] to delete the old dollar amount. It is very important not to use the spacebar to delete field information. Always use [END] when clearing a field.
 - Type the new dollar amount
 - Press [ENTER]. The system will align the numbers and insert the decimal point.
 - Correct the 0001 total charge line, if necessary.

- Any time changes are needed to a line item, delete and rekey the line items to ensure the system holds the changes.

Claims Correction – RTP Claims

Claims listed under the Claims Correction options cannot be processed as submitted, so they are assigned a Status code “T” and are Returned to Provider (RTP’d). Ordinarily, claims will remain in this status for 60 days; if they have not been corrected by the end of the suspense time, they will be purged from the system. While in the “T” status, these claims are not considered live claims, so it is very important to check for RTP’d claims on a daily or other frequent basis to maintain cash flow.

RTP’d claims can be corrected online through the Claims Correction menu, or they can be corrected in the provider’s billing system and resubmitted through the normal batch submission process. The correction method depends on several factors, i.e., if there are several claims with the same error such as a disallowed HCPCS code or missing modifiers, it probably would be more efficient to make the changes in your billing system and retransmit the claims in the next batch cycle. On the other hand, if the error doesn’t affect several claims, it may be faster to correct it online. If claims are being resubmitted through the batch process, they should be suppressed in Claims Corrections so they won’t inadvertently be corrected online and create a duplicate claim.

As discussed in the claims entry instructions, the reason code assigned to a claim may not be specific to the data field in error. This is because many of the UB-04 fields are interrelated, and the system cannot identify which one is wrong; it only can recognize that the logic among the related fields does not work. Because the fields are interrelated, sometimes changing data in a field will result in a new error and reason code. The online system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim will continue forward when nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the claim successfully passes the RTP edits, it is assigned a new receipt date. That date is used to age the claim for the 14-day payment floor.

RTP’d claims normally are displayed in receipt date order. The claim sort option allows a provider to choose a different sort order. To re-sort the DDE claims, type one of the following values in the DDE SORT field and press [ENTER]:

- “M” displays claims in Medical Record order.
- “N” displays claims in the beneficiary last name order.
- “H” displays claims in Medicare ID number order.
- “R” displays claims in Reason Code order.
- “D” displays claims in Receipt Date order.
- " " displays claims in TOB order.

To review RTP’d claims, select the appropriate menu option and press [ENTER]. The NPI and provider number fields will default to the main NPI/provider number assigned to your Operator access ID, and the outpatient type of bill will default to 13X. Check these fields and make any

necessary changes. If you want to re-sort the claim sequence, type the appropriate value in the DDE sort field and press [ENTER] again.

Once the selected claims appear, you can begin to make corrections. To do so, type “S” in the SEL field in front of the claim you want to correct. This will bring up the claim detail. As with the Claims Entry process, a reason code will be shown in the lower left corner of the screen. You can go to the Reason Code narrative by entering “17” in the SC field in the upper left corner of the screen or using the [F1] key. If you want to look up more than one reason code, simply type another code over the first and press [ENTER]. When you are ready to return to the claim, press [F3] once. Even though the error may be obvious, always check the Remarks area, claim page 4, for information the claim adjudicator may have entered that will help you make a correction or supply needed information.

Make the necessary changes. Remember to press [ENTER] after making changes to a screen to register the new information before pressing [F9]. (To exit without transmitting any corrections, press [F3] to return to the selection screen; any changes made to the screen will not be updated.) Suspend the claim back into processing by pressing [F9].

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will appear at the bottom of the screen: ‘PROCESS COMPLETED – ENTER NEXT DATA.’

Claim Suppression

If an RTP’d claim is not going to be corrected through the online process, it is recommended that you suppress it from view. This will hide the claim from view in the listing of RTP’d claims so it will not inadvertently be resubmitted, however it still will appear through the Inquiry Menu option until it is purged from the system.

To suppress a claim, type “Y” in the SV field in the upper right corner of claim page 1. Press the [F9] key. The system will return to the Claim Summary Inquiry screen.

Adjustments

Adjustments are done when a previously processed claim needs to be modified and reprocessed. By using the online adjustment options, you may call up the claim to be adjusted and make the desired changes without recreating the entire claim.

Claim adjustments are limited to claims with a Status code P (paid/finalized) or R (rejected) and should not be submitted until the claims have appeared on a remittance advice. If a claim has a status code D, the claim has been medically denied and any potential changes must be made through the redetermination process. If only a portion of the claim has been denied, the line items that have not been medically denied can be adjusted. The medically denied lines also must be handled through the redetermination process.

To make an adjustment, select the appropriate option code and press [ENTER]. This will bring up the Claim Summary Inquiry screen. The outpatient type of bill will default to 13X; check this field

and make any necessary changes. Enter your NPI, the Medicare ID number and dates of service. If the original claim was rejected, change the “P” in the S/LOC field to an “R”.

Press [ENTER]. This will bring up a listing of the claims that meet the selection criteria. Select the claim you want to adjust by placing “S” in the SEL field in front of the claim. When the claim detail appears, the type of bill will show a 7 in the final position (xxx7).

Note: When adjusting a claim that has already been adjusted, check the Paid and Cancel Date fields to identify the most recently processed version of the claim. Only the most recent version of the claim should be adjusted.

Along with making the needed changes on the claim, you will need to indicate why you are adjusting the claim by entering a change condition code on Claim Page 1 and an Adjustment Reason code on Claim Page 3. You can access a listing of the Adjustment Reason Codes by typing “16” in the SC field in the upper left corner of the screen and pressing [ENTER]. Press [F3] to return to the claim.

More than one adjustment condition code might apply to the claim, but only one can be used. A current listing of condition codes to use for adjustments and claim cancels is maintained on the Noridian website, at:

- [Jurisdiction E Condition Codes webpage:](https://med.noridianmedicare.com/web/jea/topics/claim-submission/condition-codes)
<https://med.noridianmedicare.com/web/jea/topics/claim-submission/condition-codes>
- [Jurisdiction F Condition Codes webpage:](https://med.noridianmedicare.com/web/jfa/topics/claim-submission/condition-codes)
<https://med.noridianmedicare.com/web/jfa/topics/claim-submission/condition-codes>

Simply start at the top of the list and choose the first one that applies to your adjustment. When you are done working on the claim, press [F9] to submit the claim, or [F3] to abandon the adjustment.

Cancels

Claim cancels are done when a previously processed claim needs to be voided and any payment for the services retracted. Cancels most commonly are done when the original claim was submitted under an incorrect Medicare ID number or NPI/provider number, when charges were erroneously added to a patient account, or when outpatient charges need to be bundled with an inpatient claim.

Claim cancels are limited to claims with a Status code P (paid/finalized) and should not be submitted until the claims have appeared on a remittance advice. If a claim has a status code D, the claim has been medically denied and any potential changes must be made through the redetermination process.

To cancel a claim, select the appropriate option code and press [ENTER]. This will bring up the Claim Summary Inquiry screen. The outpatient type of bill will default to 13X; check this field and make any necessary changes. Enter your NPI, the Medicare ID number and dates of service. Press [ENTER]. This will bring up a listing of the claims that meet the selection criteria. Select the claim

you want to cancel by placing “S” in the SEL field at the beginning of the row. When the claim detail appears, the type of bill will show an 8 in the final position (xxx8).

Note: When cancelling a claim that has already been adjusted, check the Paid and Cancel Date fields to identify the most recently processed version of the claim. Only the most recent version of the claim can be cancelled.

Because you are cancelling rather than modifying the claim, you will not be making changes to the claim. Instead, just enter a cancel condition code on claim page 1. The condition codes for cancel claims are:

- D5 = Correct Medicare ID number or provider ID number
- D6 = Repay a duplicate payment, OIG overpayment, inclusion of outpatient charges on inpatient PPS admission.

Once the condition code has been entered, press the [ENTER] key. Press [F9] to send the canceled claim in to be processed. Press [F3] to exit the claim submenus.