CLAIMS CORRECTION

DIRECT DATA ENTRY (DDE) MANUAL

CHAPTER 5

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Note: It is the responsibility of Medicare providers to ensure the information submitted on your billing transactions (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

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 - Part A 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 - Part A 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
```


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Correcting Claims

When a claim is submitted into the FISS, it processes 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 7 of this chapter for additional information on Medicare timely filing guidelines.

1. Enter the Claims Correction option (21, 23, or 25) 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.
   - As required in Change Request 6426 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R70MSP.pdf), Medicare secondary payer (MSP) claims and MSP adjustments where Medicare is making a secondary payment, must be submitted using the American National Standard Institute (ANSI) ASC X12N 837 5010 (electronic) format. As a result, MSP claims/adjustments submitted electronically cannot be corrected from the RTP file. Instead, electronically submitted MSP claims and adjustments that are in RTP status/location T B9997 must be resubmitted electronically using the 837 format or on a hardcopy (paper) CMS-1450 (UB-04) claim form with the correct information. MSP claims and adjustments that are allowed to be submitted direct data entry (DDE) in FISS can be corrected from the RTP file. See the "Medicare Secondary Payer Billing and Adjustments" (https://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf) quick resource tool for instructions on MSP claims and how they are submitted to Medicare.
   - 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.

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```
 MAP1741                 CGS J15 MAC - Part A 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 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
```

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. If you need to correct claims with a different type of bill, you will need to change the default TOB. A list of the default TOBs is provided below.

Claim Entry Option	Default TOB
21	11
23	13

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 - Part A 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 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.

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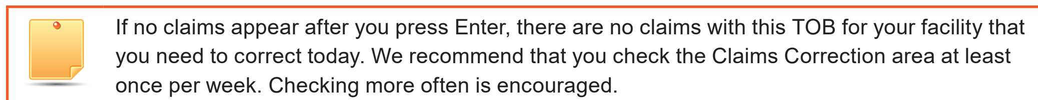
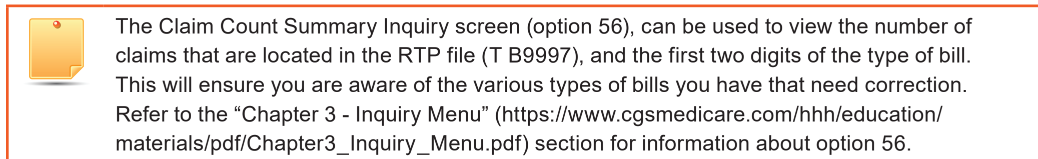
```
MAP1741                   CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC               CLAIM SUMMARY INQUIRY               C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
     MID                 PROVIDER               S/LOC T B9997  TOB XX
OPERATOR ID XXXXXX       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
  NNNNNNNNNN   XXXXXX             T B9997    131    0921XX 0101XX 0131XX   0215XX
   LASTNAME             X       272.94              0216XX        37402     11
  XXXXXXXXXX   XXXXXX             T B9997    131    0921XX 0101XX 0805XX   0215XX
   LASTNAME             X       272.94              0216XX        37402     11
  XXXXXXXXXX   XXXXXX             T B9997    131    0921XX 0101XX 0806XX   0215XX
   LASTNAME             X       272.94              0216XX        37402     11


    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.



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" (https://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter3_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 - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC               CLAIM SUMMARY INQUIRY               C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
     MID NNNNNNNNNN      PROVIDER               S/LOC T B9997  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
 _ NNNNNNNNNN   XXXXXX             T B9997    131    0921XX 0101XX 0131XX   0215XX
   LASTNAME             X       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.

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```
MAP1711    PAGE 01           CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX     SC                 INST CLAIM UPDATE                  C20112WS HH:MM:SS
 MID 123456789A     TOB 131  S/LOC S B0100 OSCAR XXXXXX          SV:     UB-FORM
NPI XXXXXXXXXX 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
32402
      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.

```
MAP1881                       CGS J15 MAC - HHH REGION         ACPFA052 MM/DD/YY
XXXXXX     SC           REASON CODES INQUIRY                   C20112WS HH:MM:SS
                                                            MNT: CMSSTD    050710
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   32402    E   080100                                  T        T
 TPTP A     B    NPCD A     B     HD CPY A     B    NB ADR     CAL DY      C/L C
  ------------------------------NARRATIVE-------------------------------------
HCPCS CODE REPORTED ON THIS CLAIM HAS NOT BEEN BILLED WITH A VALID REVENUE CODE
FOR THE DATES OF SERVICE.
VERIFY BILLING AND IF APPROPRIATE, CORRECT.
** ONLINE PROVIDERS:  PRESS PF9 TO STORE THE CLAIM.
** OTHER  PROVIDERS:  RETURN TO THE INTERMEDIARY.


       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

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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 Skilled Nursing Facility (SNF) claim with a sequential billing error, a prior claim may need to be submitted or corrected. 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, information may be added 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, wMIDh 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” (https://www.cgsmedicare.com/Articles/COPE18411.html) CGS Web page.

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

```
MAP1741                    CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC                 CLAIM SUMMARY INQUIRY               C20112WS HH:MM:SS
                                NPI XXXXXXXXXX
     MID NNNNNNNNNN     PROVIDER               S/LOC T B9997   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
 NNNNNNNNNN    XXXXXX             T B9997     131    0921XX 0101XX 0131XX   0215XX
  LASTNAME               X        272.94            0216XX         37402      11
```


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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 - Part AREGION            ACPFA052 MM/DD/YY
XXXXXX     SC                 INST CLAIM UPDATE                   C20112WS HH:MM:SS
 MID NNNNNNNNNNA     TOB 813  S/LOC S B0100 OSCAR XXXXXX          SV:    UB-FORM
NPI XXXXXXXXXX TRANS HOSP PROV                    PROCESS NEW MID  Y NNNNNNNNNNA
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.

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.
- 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 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 lines, update the total charge amount on the 0001 revenue code line to reflect the correct amount

```
MAP1712     PAGE 02         CGS J15 MAC - Part A REGION    ACPFA052 MM/DD/YY
XXXXXX      SC              INST CLAIM ENTRY               C201135E HH:MM:SS
                                                   REV CD PAGE 01
MID                   TOB XXX   S/LOC S B9997   PROVIDER
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 D551  G0299           104.910  00002 00002     100.00             0229XX
 5 0001                                      250.00
       PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

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.

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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 - Part A REGION        ACPFA052 MM/DD/YY
XXXXXX     SC                INST CLAIM UPDATE                  C20112WS HH:MM:SS
 MID 123456789A     TOB 131  S/LOC S B0100 OSCAR XXXXXX         SV: Y   UB-FORM
NPI XXXXXXXXXX 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;
- Change Medicare from the primary payer to the secondary payer. (MSP: Condition, Occurrence, Value, and Patient Relationship, and Remarks Field Codes, https://www.cgsmedicare.com/parta/pubs/news/2013/0213/cope21194.html);
- 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

Medicare timely filing requirements apply to claim adjustments. Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements for submission of claims. The "Through" date is used to determine whether the claim has been filed timely. Please see Medicare Learning Network® (MLN) Matters article, MM7396 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7396.pdf) for information about timely filing.

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, wMIDh is found on FISS screen Map 171D.

1. To adjust paid or rejected claims, enter the Claims Adjustments option (21,23, or 25) that matches your provider type and press ***Enter***.

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```
MAP1704                    CGS J15 MAC - Part A 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 - Part A 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***.

   The **TOB** field automatically displays the first two digits of the default type of bill based on the adjustment option that you selected.
6. You may also enter the 'From Date' and 'To Date' of the claim, but that is optional.
7. 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.

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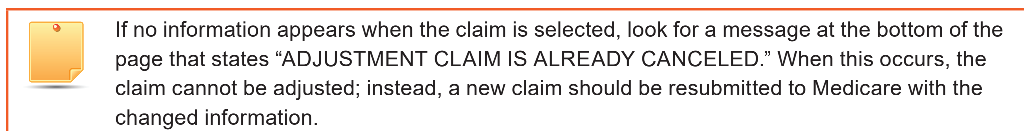
```
MAP1741                CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX     SC             CLAIM SUMMARY INQUIRY             C20112WS HH:MM:SS
                              NPI
      MID                 PROVIDER                S/LOC P        TOB XX
 OPERATOR ID XXXXXX      FROM DATE         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
```

```
MAP1741                CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX     SC             CLAIM SUMMARY INQUIRY             C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
     MID NNNNNNNNNN      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
  NNNNNNNNNN    XXXXXX             P B9997    XXX    0624XX 0624XX 0630XX    0720XX
   LASTNAME               X      272.94               0816XX          37192

  NNNNNNNNNN    XXXXXX             P B9997    XXX    0624XX 0701XX 0731XX    0819XX
   LASTNAME               X      272.94               0901XX          37192

  NNNNNNNNNN    XXXXXX             P B9997    XXX    0624XX 0801XX 0831XX    0913XX
   LASTNAME               X      272.94               0927XX          37192


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

8. 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 - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX     SC             CLAIM SUMMARY INQUIRY             C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
     MID NNNNNNNNNN      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
 __ NNNNNNNNNN    XXXXXX           P B9997    XXX    0624XX 0624XX 0630XX    0720XX
   LASTNAME               X      272.94               0816XX          37192
```

9. 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.

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```
MAP1711    PAGE  01           CGS J15 MAC - Part A REGION           ACPFA052 MM/DD/YY
XXXXXX     SC                  INST CLAIM ADJUSTMENT               C20112WS HH:MM:SS
 MID NNNNNNNNNN     TOB 137  S/LOC S B0100 OSCAR XXXXXX           SV:    UB-FORM
NPI XXXXXXXXXX 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                  FAC.ZIP
  DCN 20060200032208XXX
       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
```

Need example for OP Claim

10. Adjustments are a four-step process. You must:

   a. Enter a Claim Change Reason Code on Page 01 of the claim;
   b. Enter an Adjustment Reason Code on Page 03 of the claim;
   c. 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.

   d. 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 code 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.

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```
MAP1711    PAGE 01          CGS J15 MAC - Part A REGION            ACPFA052 MM/DD/YY
XXXXXX     SC                 INST CLAIM ADJUSTMENT              C20112WS HH:MM:SS
 MID NNNNNNNNNN    TOB 137  S/LOC S B0100 OSCAR XXXXXX             SV:    UB-FORM
NPI XXXXXXXXXX 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
04                    05                  06                    07
08                    09                  10                    FAC.ZIP
```

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.

```
MAP1713    PAGE 03           CGS J15 MAC - PartA REGION       ACPFA052 MM/DD/YY
XXXXXX     SC                 INST CLAIM ENTRY              C201135E HH:MM:SS
MID                  TOB XXX  S/LOC S B0100  PROVIDER
NDC CD                              OFFSITE ZIP:      ADJ MBI            IND
CD  ID     PAYER                     OSCAR         RI AB          EST AMT DUE
```

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***.

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.

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- 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 our website at: https://www.cgsmedicare.com/parta/cs/.
- 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 131 type of bill and the adjustment is listed as an 137. In addition, the CAN DT of the original claim will match the PD DT of the adjusted (137) claim.

```
MAP1741                  CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
XXXXXX    SC               CLAIM SUMMARY INQUIRY           C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
     MID NNNNNNNNNN     PROVIDER                 S/LOC P B9997   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
  NNNNNNNNNN    XXXXXX               P B9997    131    0624XX 0624XX 0630XX  0720XX
   LASTNAME            X        839.40               0816XX 1101XX       37192

  NNNNNNNNNN    XXXXXX               P B9997    137    0624XX 0701XX 0731XX  0819XX
   LASTNAME            X        852.40               1101XX          37192


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

- 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., 13G, 13I). A cancel should not be made to an adjustment initiated by CGS or CWF. Instead, an adjustment should be submitted if the 13G or 13I 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.

1. 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.

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```
MAP1711   PAGE 01          CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC                INST CLAIM ADJUSTMENT              C20112WS HH:MM:SS
 MID NNNNNNNNNNN    TOB 138  S/LOC S B0100 OSCAR XXXXXX         SV:    UB-FORM
NPI XXXXXXXXXX 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 20060200032208XXX
       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

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

Cancellations are a three-step process. You must:

a. Enter a Claim Change Reason Code on Page 01 of the claim;

b. Enter an Adjustment Reason Code on Page 03 of the claim; and

c. Press F9 to submit the cancellation.

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

2. **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:

Code	Description
D0	Changes to Service Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS/HIPPS
D3	Second or Subsequent Interim PPS Bill
D5	Cancel to correct Medicare ID or Provider ID
E0 (zero)	Change in patient Status
D6	Cancel only to repay a duplicate OIG payment
D7**	Change to Make Medicare Secondary Payer
D8	Change to Make Medicare Primary Payer
D4	Changes in Grouper Codes
D9***	Any Other Change

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```
MAP1711    PAGE  01            CGS J15 MAC - Part A REGION           ACPFA052 MM/DD/YY
XXXXXX     SC                   INST CLAIM ADJUSTMENT               C20112WS HH:MM:SS
 MID NNNNNNNNNN    TOB 138  S/LOC S B0100 OSCAR XXXXXX               SV:    UB-FORM
NPI XXXXXXXXXX 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
       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
```

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.

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 website at: https://www.cgsmedicare.com/parta/cs/.

The original paid or rejected claim, 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 131 type of bill and the cancellation is listed as a 138. In addition, the CAN DT of the original claim will match the PD DT of the cancel (131) claim.

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```
MAP1741                   CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC                CLAIM SUMMARY INQUIRY              C20112WS HH:MM:SS
                               NPI XXXXXXXXXX
     MID NNNNNNNNNN     PROVIDER                 S/LOC P         TOB
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
  NNNNNNNNNN   XXXXXX              P B9998    131    0624XX 0624XX 0624XX   0629XX
   LASTNAME             X                  1520.00 0703XX  1101XX       37192

  NNNNNNNNNN   XXXXXX              P B9997    138    0624XX 0701XX 0731XX   0819XX
   LASTNAME             X                  1520.00 1101XX         37192
```

To avoid billing errors, ensure that the "cancel" claim (XX8 type of bill) is in FISS S/LOC P B9997 prior to submitting a new 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 Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements to 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 - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC                CLAIM SUMMARY INQUIRY              C20112WS HH:MM:SS
                               NPI XXXXXXXXXX
     MID NNNNNNNNNN     PROVIDER                 S/LOC P         TOB
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
  NNNNNNNNNN   XXXXXX              P O9998   XXX    0523XX 0523XX 0524XX   0603XX
                             63413.57                0617XX        XXXXX
```

1. To retrieve an archived claim, access the Claim and Attachments Correction Menu (option 03 from the FISS Main 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
```

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 wMIDh the retrieval was requested will appear the following Monday in status/location P B9997 (if claim was

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originally paid), or R B9997 (if claim was originally rejected). At that time, you are able to view the claim data.

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