ANNOUNCING

The Billed Amount, Procedure Code, and Both Combined Adjustment Request Form

In the comings months, CGS will introduce a number of new forms to request specific types of Reopenings. This process improvement will help facilitate our efforts to automate Reopenings, which will, in time, result in a more efficient process.

The third in a series of new forms is the Medicare Part B Reopenings Billed Amount, Procedure Code, and Procedure Code and Billed Amount Adjustment Request Form (http://www.cgsmedicare.com/partb/forms/pdf/billing_adjustment_form.pdf). This form will allow you to request simple corrections specific to adding or replacing a billed amount, a procedure code, or a combined billed amount and procedure code on a previously processed claim. Only one claim can be corrected per form; up to 10 billed amount, procedure code, or combined corrections can be made.
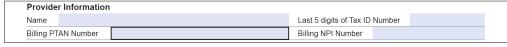
In order to use the new form, you must have access to your Remittance Advice (RA), as information from the RA must be entered into specific fields of the form. To address legibility issues, we encourage you to complete the form online, and then print it.

Reopenings Billed Amount, Procedure Code, Procedure Code and Billed Amount Adjustment Request Form Instructions

- Complete the header of the form:

State	Kentucky ☐	Ohio ☐	Date
Contact			

  - Select the State

  - Enter the date the form is completed

  - Enter a contact person's name and telephone number

- Complete the *Provider Information* section:

Provider Information

Name		Last 5 digits of Tax ID Number	
Billing PTAN Number		Billing NPI Number	

  - Enter the Provider's Name

  - Identify the last 5 digits of Tax ID number

  - Enter the Billing PTAN *(Individual physicians/practitioners who reassign benefits to a group, enter the Group PTAN. Solo physicians/practitioners, enter the Individual PTAN.)*

  - Enter the Billing NPI *(Individual physicians/practitioners who reassign benefits to a group, enter the Group NPI. Solo physicians/practitioners, enter the Individual NPI.)*

- Complete the *Beneficiary Information* section:

Beneficiary Information

Name	
Medicare Number	Date of Birth

  - Enter the Beneficiary's Name

  - Beneficiary Medicare Number

    NOTE: To avoid processing delays, verify that the Beneficiary Medicare Number is correct.

  - Enter the Beneficiary's Date of Birth

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- Identify the Claim information:

Service Date	HCPCS	ICN

- Enter the first *Date of Service* for the claim

- Identify the *HCPCS/CPT Code* (procedure code)

- Enter the *Internal Control Number (ICN)* of the claim, which is located on the RA.

  NOTE: Verify that the ICN is accurate. Incorrect, incomplete, or invalid ICNs will result in increased processing time (up to 60 days).

- Complete the *Reason for Request* section:

Reason for Request

This request is for an MSP (Medicare Secondary Payer):	☐
This request is for Non-MSP (Non - Medicare Secondary Payer):	☐

- Select *Medicare Secondary Payer (MSP)* for requests involving other insurance

  NOTE: MSP cases require additional steps and, therefore, will not be included in the automation process. Therefore, it may take up to 60 days to process MSP Reopenings.

- Select *Non-MSP* for all other requests

- Complete each column of the *Adjustment Details* section using information from the RA:

Adjustment Details

Line	Adjustment Type (B = Billed Amount, P = Procedure Code, Z = Both)	New Value (Procedure Code)	New Value (Billed Amount)

- Identify the *Line* you wish to have corrected.

  Example: If the RA shows the claim was submitted with nine line items, and the correction is needed on line six of the claim, enter '6'. (A value of 1-13 may be entered in this field.)

- Identify the Adjustment Type:

  » *B* – Billed Amount correction only

  » *P* – Procedure Code correction only

  » *Z* – Billed Amount and Procedure Code (both) correction

- Identify the *New Value (Procedure Code)*, if applicable. This field will be used when selecting *Adjustment Type* of *P* or *Z* only. Enter the new, updated procedure code.

  NOTE: Modifiers cannot be updated or added using this form. This form is for procedure codes and billed amounts only. If a modifier correction is required, as well as a procedure code change, the Part B Reopenings Adjustment Request Form (http://cgsmedicare.com/forms/reopening_form.pdf) must be used. Automation for these will not apply, therefore, it could take up to 60 days for your request to process.

- Identify the *New Value (Billed Amount),* if applicable. This field will be used when selecting the *Adjustment Type* of *B* or *Z* only.

Please note the following:

- For the *Adjustment Type* column:

  - Type *'Z'* must have information in both the *New Value (Procedure Code)* and *New Value (Billed Amount)* fields.

  - Type *'B'* must have information entered in the *New Value (Billed Amount)* field only.

  - Type *'P'* must have information entered in the *New Value (Procedure Code)* field only.

Example: To update the billed amount on one line, the procedure code on another line, and both the procedure code and the billed amount on a third line, complete the Adjustment Type column as follows:

Adjustment Details

Line	Adjustment Type (B = Billed Amount, P = Procedure Code, Z = Both)	New Value (Procedure Code)	New Value (Billed Amount)
1	B		200.00
2	P	99218	
3	Z	99214	150.00

Please pay special attention to the Adjustment Details section. Forms submitted with inaccurate, incomplete, or missing Line and/or New Values may result in increased processing time of up to 60 days.