

# Reducing Unprocessable Claims

1/28/2025

**Closed Captioning:** *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

# Today's Presenters

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# Objective

After today's session, you'll understand the importance of submitting a claim the first time with all the required facts for NGS to process the claim.



# Agenda

- [Claim Requirements](#)
- [Reducing Claim Rejections for Beneficiary Eligibility](#)
- [Reducing Claim Rejections for Provider Information and Data](#)
- [Reducing Claim Rejections for Clinical Laboratory Improvement Amendment](#)
- [Reducing Claim Rejections for Missing Billed Charges](#)
- [Reducing Claim Rejections for Missing Documentation](#)
- [Reducing Claim Rejections for Drug Name Strength and Dosage](#)
- [Reducing Claim Rejections for Date Last Seen by Attending Physician for Routine Foot Care](#)
- [Reducing Claim Rejections for Place Where Services are Rendered](#)
- [Reducing Claim Rejections for Services Not Payable Under NGS Jurisdiction](#)
- [Reducing Claim Rejections for CPT and HCPCS Codes and Modifiers](#)

# Claim Requirements

# Claim Requirements

- If claims do not conform to NGS specifications, they will be returned
- NGS' initiative is to reduce the number of unprocessable claims
- Goal is to get your claims accurately processed the first time



# Unprocessable Claims

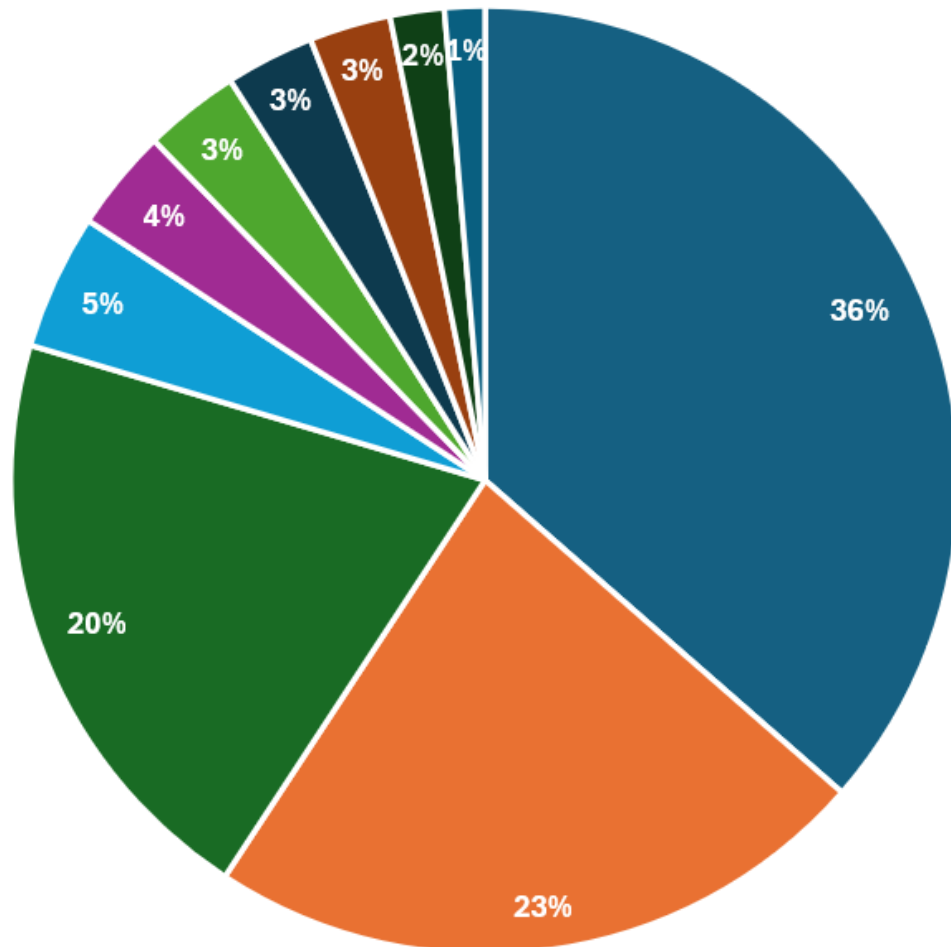
- Information is
  - Invalid
  - Missing
  - Insufficient
  - Incomplete
- Claims will be rejected
- Must submit a new claim
- No appeal rights granted
- Methods for rejection
  - Remittance advice shows an MA130
  - Additional remark code used to identify the error
- Paper claims are screened
  - Form letter sent back indicating the error
- Electronic claims
  - Fall initial edits



# Remittance Example and References

| Code             | Description  |
|------------------|--|
| CO-16            | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Additional information is supplied using remittance advice remarks codes. Note: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF) |
| MOA Code<br>MA27 | Missing, incomplete or invalid entitlement number or name shown on the claim submitted   |
| WPC References   | <a href="#">X12 Claim Adjustment Group Codes</a> <ul style="list-style-type: none"><li>• Remittance Advice Remark Codes Reference</li><li>• Claim Adjustment Reason Code Reference</li></ul>   |

# Q4 2024 J6 and JK Claim Rejection Data

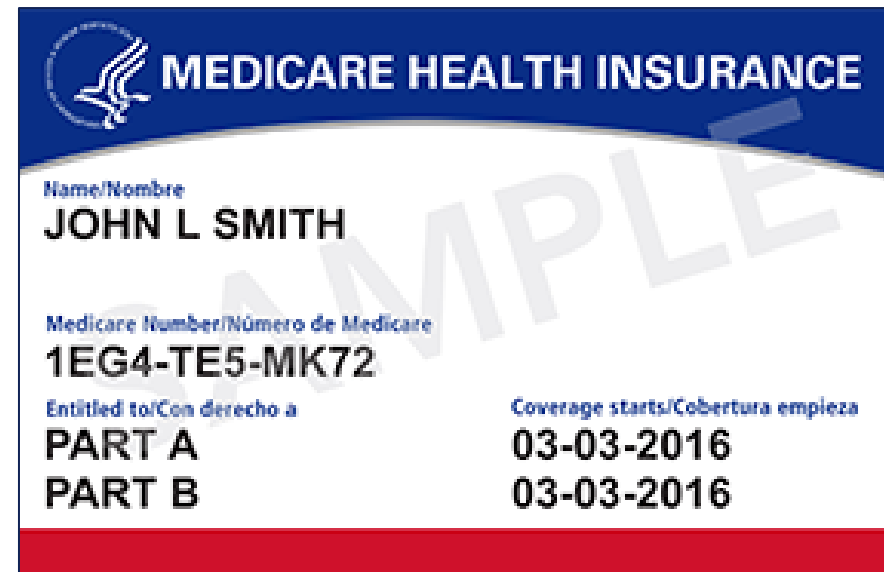


- 36% Patient identifier and RRB
- 23% Group, rendering and ordering
- 20% HCPCS/CPT and modifiers
- 5% Drug name strength and dosage
- 4% No charge indicated
- 3% Not NGS Jurisdiction
- 3% Missing date last seen and attending physician NPI for routine foot care
- 3% CLIA certification
- 2% Missing documentation
- 1% Invalid place where services were furnished

Reducing Claim Rejections for  
Beneficiary Eligibility (36%)

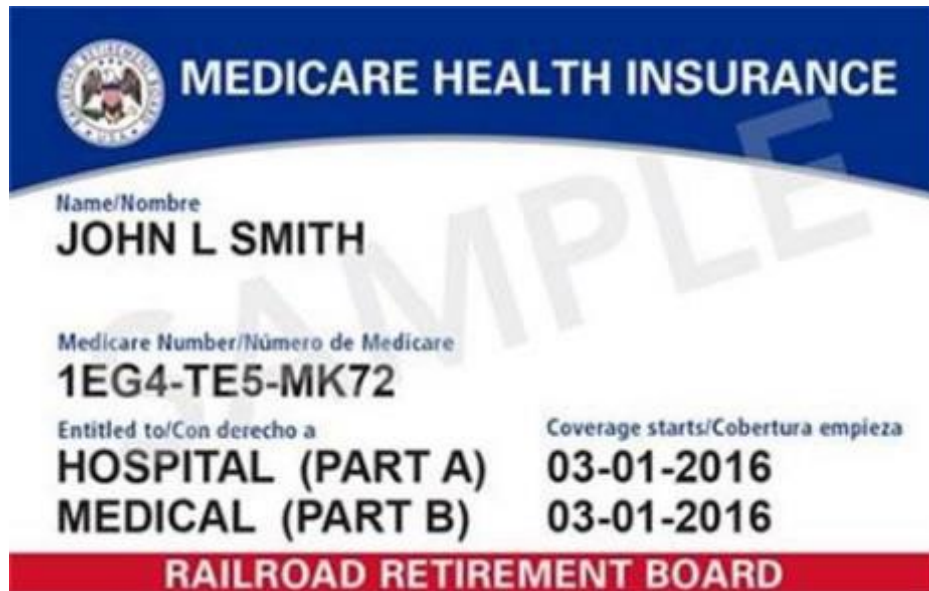
# Beneficiary Eligibility

- PR-31
  - Name or MBI was incorrect or missing
  - Date of death precedes date of service
  - Expenses incurred prior to coverage or after coverage terminated
  - Not covered by Medicare at time patient received services





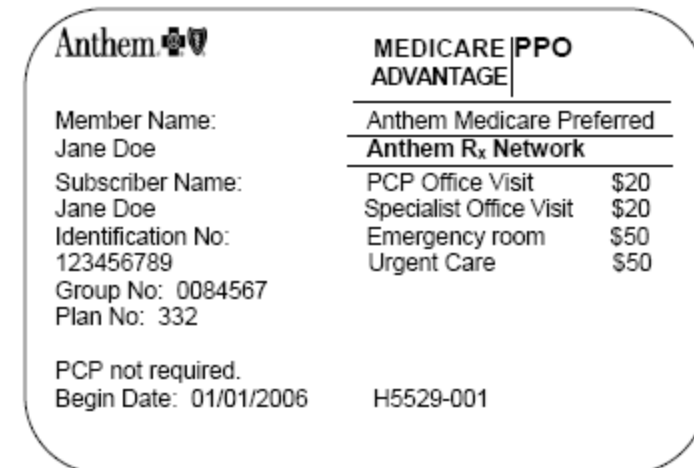
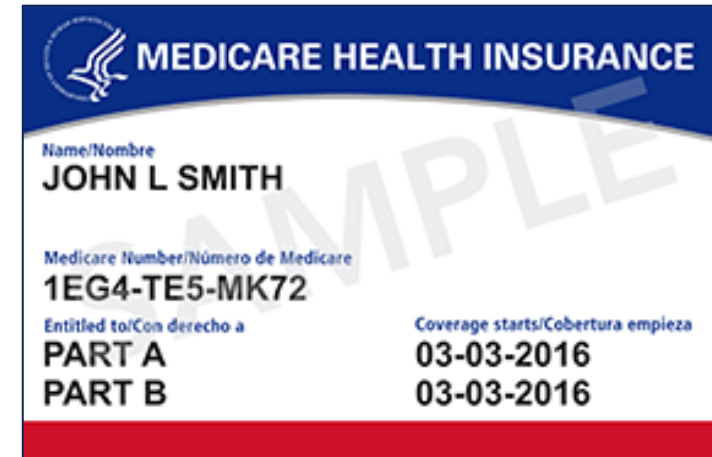
# Railroad Retirement Board Eligibility



- N105
- Misdirected claim for RRB beneficiary
- Submit claims to the RRB carrier
  - Palmetto GBA  
P.O. Box 10066  
Augusta, GA 30999  
866-749-4301

# Medicare Advantage Eligibility

- OA-109
  - Yearly open enrollment
    - Usually October 15th–December 7th
- Private health plans for members' health care and claims must be sent to MA plan
- Screen beneficiaries
- Provider self service
  - NGSConnex



# NGSConnex Beneficiary Eligibility Verification Requirements

- Four beneficiary data elements required
  - Last name
  - First name or initial
  - MBI
  - Date of birth

The screenshot shows the NGSConnex web interface for beneficiary eligibility verification. The page has a dark blue header with the 'connex' logo and a 'HOME' link. A 'Printable View' button is highlighted with a red box in the top right corner. On the left, a sidebar menu lists various eligibility categories, with 'Beneficiary Eligibility' selected. The main content area is titled 'Beneficiary Eligibility' and contains a 'Beneficiary Information' section with the following fields:

| Beneficiary Information |                |                |
|-------------------------|----------------|----------------|
| Medicare Number         | Last Name      | First Name     |
| 2DV-██████              | ██████         | ██████         |
| MBI Term Date           | Date of Birth  | Date of Death  |
| ██████                  | 12-██████      | ██████         |
| Sex                     | Address Line 1 | Address Line 2 |
| Female                  | PO BOX ██████  | ██████         |
| City                    | State          | Zip            |
| MINNEAPOLIS             | MN             | 55405-██████   |

# Steps to Successfully Check Eligibility

- Collect all insurance data from beneficiary
- [NGSConnex](#)
- Effective 11/18/2024, the beneficiary eligibility lookup function has been disabled on the IVR





Reducing Claim Rejections for  
Provider Information and Data (23%)

# Ordering and Referring Provider Information

- N264, N265, N285, N286 provider name and NPI
  - Provider who orders item or services
  - Provider who requests an item or service
    - Clinical laboratories
    - Diagnostic imaging
- Missing, incomplete or invalid provider identifier
  - Line items 17 and 17b or electronic equivalent
  - No nick names
  - First and last name as it appears in PECOS
    - Ordering = DK
    - Referring = DN
    - Supervising = DQ

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. X X

17b. NPI

| Item No. | Claim Description                           | Loop  | Field      | Data Element Description       | Requirements   |
|----------|---|-------|------------|--------------------------------|--|
| 17       | Name of Referring physician or other source | 2310A | NM103 (DN) | Referring provider last name   | Required if claim involved a referral or services were ordered. When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (2310A) loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separate claim must be billed for each ordering/referring physician. |
|          |   |       | NM104      | Referring provider first name  |  |
|          |   |       | NM105      | Referring provider middle name |  |
|          | Name of Ordering physician                  | 2420E | NM103 (DN) | Referring provider last name   |  |
|          |   |       | NM104      | Referring provider first name  |  |
|          |   |       | NM105      | Referring provider middle name |  |
| 17a      | Other ID number of Referring physician      |       |            |                                |  |
| 17b      | NPI   | 2310A | REF02 (1C) | Referring provider primary ID  |  |
|          |   |       | REF02 (1C) |                                | Enter "XX" in the NM108 to indicate an NPI is present in the NM109. Enter the NPI of the referring/ordering physician listed in Item 17  |
|          |   |       | REF02 (1C) | Ordering provider primary ID   |  |

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/00/0012

|   |  |   |  |
|---|--|---|--|
| 1. MEDICARE<br><input type="checkbox"/> MEDICARE<br><input type="checkbox"/> MEDICAID<br><input type="checkbox"/> TRICARE<br><input type="checkbox"/> CHAMPVA<br><input type="checkbox"/> OTHER HEALTH PLAN (OHP)<br><input type="checkbox"/> SEVERE ILLNESS (SIL)<br><input type="checkbox"/> OTHER (OW) |  | 16. INSURED'S I.D. NUMBER (For Program in Item 1)   |  |
| 2. PATIENT'S NAME (Last name, first name, middle initial)   |  | 4. INSURED'S NAME (Last name, first name, middle initial)   |  |
| 5. PATIENT'S ADDRESS (No., Street)  |  | 7. INSURED'S ADDRESS (No., Street)  |  |
| CITY  |  | CITY  |  |
| STATE   |  | STATE   |  |
| ZIP CODE  |  | ZIP CODE  |  |
| TELEPHONE (Include Area Code)   |  | TELEPHONE (Include Area Code)   |  |
| 9. OTHER INSURED'S NAME (Last name, first name, middle initial)   |  | 11. INSURED'S POLICY GROUP OR POLICY NUMBER   |  |
| 10. IS PATIENT'S CONDITION RELATED TO:  |  | 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F)  |  |
| a. EMPLOYMENT (Current or Previous)<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | b. OTHER CLAIM ID (as guided by NUCC)   |  |
| c. AUTO ACCIDENT? (PLACE SIGN)<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | c. INSURANCE PLAN NAME OR PROGRAM NAME  |  |
| d. OTHER ACCIDENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, complete items 16, 17a, and 18)                   |  |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of government benefits either to myself or to the party who accepts assignment below.)  |  | 15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) |  |
| 14. DATE OF CURRENT SERVICE (Include if Program is Claim)   |  | 16. DATE OF BIRTH (Include if WORK-RELATED OCCUPATION)  |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES   |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL ICD-9-CM codes below)   |  | 22. PRELIMINARY CODES ORIGINAL PIP NO.  |  |
| 23. PRIOR AUTHORIZATION NUMBER  |  | 24. A. DATES OF SERVICE FROM TO PLACE OF SERVICE  |  |
| B. PROCEDURE, SERVICE OR SUPPLIER (Specify Universal Ordinance) ICD-9-CM  |  | C. DIAGNOSIS POSITION   |  |
| D. CHARGES  |  | E. CHARGE   |  |
| 25. FEDERAL TAX ID NUMBER   |  | 26. PATIENT'S ACCOUNT NO.   |  |
| 27. SERVICE ASSIGNMENT? (YES/NO)  |  | 28. TOTAL CHARGE  |  |
| 29. AMOUNT PAID   |  | 30. FINDER'S FEE (if any)   |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials and certify that the standards or requirements apply to this bill and on it with a part thereof.)  |  | 32. SERVICE FACILITY LOCATION INFORMATION   |  |
| 33. BILLING PROVIDER INFO & PIP#  |  | 34. BILLING PROVIDER INFO & PIP#  |  |

# Rendering and Billing Provider Information

- Individual or Organization billing provider data
  - Type 1 (Individual)
  - Type 2 (Organization)
- Medical group or other entity entitled to bill and receive payment for physician services
  - Each physician/NPP rendering services under the group will be identified in 24J
- Line Item 33 or electronic equivalent
  - Billing provider



# Steps to Successfully Check Provider Data

- [Data Files for Ordering and Referring](#)
- [National Plan & Provider Enumeration System](#)
- [Medicare Place of Service Code Set and Descriptions](#)
- [CMS-1500 Claim Form](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)





Reducing Claim Rejections for  
Clinical Laboratory Improvement  
Amendment (3%)



# Clinical Laboratory Improvement Amendments

- Quality standard for laboratory testing to ensure accuracy, reliability and timeliness of patient test results
- Different types of waivers are available
  - Effective for two years
- Some CLIA waived tests required modifier QW
  - Item 24D right of CPT/HCPCS code
- Enter ten-digit CLIA number for laboratory services billed by an entity performing CLIA-covered procedures
  - Item 23 or electronic equivalent

# Steps to Successfully Check CLIA Information

- [Clinical Laboratory Fee Schedule](#)
- [Clinical Laboratory Improvement Amendments \(CLIA\)](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 16](#)



Reducing Claim Rejections for  
Missing Billed Charges (4%)



# Invalid Charges

- Each line submitted should have valid charge
- If there are no cents in charge amount, enter 00
- Codes with zero-charge used for reporting purposes may be billed with a 0.01
- Total charges in line Item 24F or electronic equivalent
- Multiple claim forms with “continued” or “see next page” or single total in Item 28 for multiple claim forms will be returned as unprocessable

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Champion) GROUP HEALTH PLAN (Group Health Plan) IS OR WAS (Is or Was) OTHER (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) YES NO b. ALSO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO 11. INSURED'S POLICY OR GROUP OR FEDCA NUMBER 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits other to myself or to the party who accepts assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM, DD, YY) QUAL. 15. OTHER DATE (MM, DD, YY) 16. DATE (MM, DD, YY) WHEN I AMABLE TO WORK IN CURRENT OCCUPATION FROM TO 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (SSN, 17A, NP) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO) 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? (YES, NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in verbatim below) (ICD-9-CM) (ICD-10) 22. PRESCRIPTION CODE ORIGINAL RFP NO. 23. PRIOR AUTHORIZATION NUMBER 24. A. DATES OF SERVICE (From, To) B. PLACE OF SERVICE (ICD-9-CM) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. CHARGE (ICD-9-CM) F. CHARGE (ICD-9-CM) G. CHARGE (ICD-9-CM) H. CHARGE (ICD-9-CM) I. CHARGE (ICD-9-CM) J. CHARGE (ICD-9-CM) K. CHARGE (ICD-9-CM) L. CHARGE (ICD-9-CM) 25. FEDERAL TAX ID NUMBER (SSN) 26. PATIENT'S ACCOUNT NO. 27. ACCENT ASSIGNMENT? (YES, NO) 28. TOTAL CHARGE \$ CHARGES (NP1) (NP1) (NP1) (NP1) (NP1) (NP1) 29. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE OR CREDENTIALS if any) that the standards or the laws apply to the bill and on train a part thereof) 30. SERVICE FACILITY LOCATION INFORMATION 31. SERVICE FACILITY LOCATION INFORMATION 32. SERVICE FACILITY LOCATION INFORMATION 33. SERVICE FACILITY LOCATION INFORMATION 34. SERVICE FACILITY LOCATION INFORMATION 35. SERVICE FACILITY LOCATION INFORMATION 36. SERVICE FACILITY LOCATION INFORMATION 37. SERVICE FACILITY LOCATION INFORMATION 38. SERVICE FACILITY LOCATION INFORMATION 39. SERVICE FACILITY LOCATION INFORMATION 40. SERVICE FACILITY LOCATION INFORMATION 41. SERVICE FACILITY LOCATION INFORMATION 42. SERVICE FACILITY LOCATION INFORMATION 43. SERVICE FACILITY LOCATION INFORMATION 44. SERVICE FACILITY LOCATION INFORMATION 45. 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Line-item 24F= loop 2400, field SV102  
 Line-item 28= loop 2300, field CLM02

# Steps to Successfully Check Billed Charges

- [CMS-1500 Claim Form Completion Instructions](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



Reducing Claim Rejections for  
Missing Documentation (2%)

# Additional Documentation Requests

- NGS may need to analyze claims to determine compliance
  - Any claim submitted may be selected for review
- ADR letters will be generated
  - NGS may require clarification or documentation
    - If documentation is not submitted, claim rejects as unprocessable
- Each ADR will include
  - Contractor requesting the medical documentation
  - Services in question
  - Reason for the request
  - Which records are being requested
  - Date records are due
  - How and where to submit your records

# Ways to Respond to ADRs

- Utilizing Paperwork Segment and esMD
  - Use one PWK Medicare Fax/Cover Sheet for each electronic claim documentation
  - Send the additional documentation after the claim has been electronically submitted with the PWK segment
  - [Medicare JK Part B PWK Fax/Mail Cover Sheet](#)
  - [Medicare J6 Part B PWK Fax/Mail Cover Sheet](#)
- Electronic Submission of Medical Documentation
  - Any provider who would like to electronically submit medical documentation may either
    - Build a gate
    - Procure gateway services
      - [Electronic Submission of Medical Documentation \(esMD\)](#)
- NGSConnex
  - See the [NGSConnex User Guide](#)



# Ways to Respond to ADRs

- Fax
  - Some NGS ADR letters will contain specific fax numbers based on the department requesting the documentation
  - Submission to an incorrect fax number will delay claim processing
  - Verify the fax number used matches the fax number on the ADR letter
    - NOTE: If a fax number is not included in the ADR letter, then faxing the documentation is not allowed
- U.S. Mail, FedEx, UPS
  - A direct mailing address is included in all ADR letters
  - Send the original ADR with the requested documentation
  - Retain a copy of the ADR letter
  - Only send the requested documentation



# Claim Additional Development Requests

- Common situations that would require additional documentation to process a claim
  - NOC codes or unlisted codes
  - Modifier 22 – Unusual Services
  - Modifier 52 – Reduced Services
  - Modifier 53 – Discontinued Services
  - Modifier 62 – Co-surgery
  - Modifier 66 – Team Surgery
- Check NGSConnex
- Consider the Electronic Claims Attachments 275/277
  - [Benefits of 275 Electronic Attachment](#)
  - [Benefits of 277 Electronic Attachment](#)

# Steps to Successfully Provide Required Documentation

## Additional Development Request Letters Guide

- [Ways to Respond](#)
- [Claim Additional Development Requests](#)
- [MR TPE Additional Development Requests](#)
- [Other Audit Contractor Additional Development Requests](#)
- [Overpayments Due to Contractor Audit Reviews](#)
- [EDI Solutions Benefits of Electronic Attachments ANSI 275](#)
- [EDI Solutions Benefits of the 277 RFI ANSI 277](#)



Reducing Claim Rejections for Drug  
Name Strength and Dosage (5%)

# Drug Name, Strength and Dosage

- When billing drugs or biologicals, name, dosage and invoice price must be entered in line item 19 of CMS-1500 paper claim form or electronically [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#) in loop 2300/2400, NTE field
- Example of how the information should appear in notes section of claim
  - Drug: Liorseal
  - Dosage: 80,000 MCG
  - Invoice Price: \$2,376.37

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER (LMS) OTHER  
 (Medicare)  (Medicaid)  (TRICARE)  (Champion)  (Group Health Plan)  (Deer)  (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. & Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. & Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO: 10. IS THERE ANOTHER HEALTH BENEFIT PLAN? 11. INSURED'S POLICY OR GROUP OR FICA NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits after to myself or to the party and accept assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL 15. OTHER DATE (MM DD YY) QUAL 16. DATES (START AND END) TO WORK IN CURRENT OCCUPATION (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Assigned by NTE)

20. OUTSIDE LAB?  YES  NO

21. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) 22. SERVICE FACILITY LOCATION INFORMATION 23. BILLING PROVIDER INFO & P.I.F. ( )

24. FEDERAL TAX ID NUMBER 25. PATIENT'S ACCOUNT NO. 26. ACCOUNT ASSIGNMENT? (YES/NO) 27. TOTAL CHARGE 28. AMOUNT PAID 29. FINE FOR NUCC USE

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on this invoice apply to this bill and are made a part thereof.) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & P.I.F. ( )



# Steps to Successfully Check Drug Name Strength and Dosage

- [Medicare Part B Drug Coverage](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals](#)
- [Unlisted Codes for Drugs and Biologicals \(J3490, J3590 and J9999\)](#)
- [CMS-1500 Claim Form Completion Instructions](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



Reducing Claim Rejections for Date  
Last Seen by Attending Physician for  
Routine Foot Care (3%)



1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEOR (LIFE) OTHER  
 (Medicare)  (Medicaid)  (TRICARE)  (Champion)  (Group Health Plan)  (Deor)  (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other) 7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (3rd or Area Code) 9. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO 11. INSURED'S POLICY OR GROUP OR POLA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits other to myself or to the party who accepts assignment below. SIGNED DATE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM DD YY) 15. OTHER DATE (MM DD YY) 16. DATES OF WORK RELATED TO CURRENT OCCUPATION (FROM TO) (MM DD YY) (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY) (MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB \$ CHARGE YES NO 21. PHYSICIAN CODE ORIGINAL REF NO 22. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE OF SERVICE (From To) (MM DD YY) (MM DD YY) | B. PLACE OF SERVICE (EMS) | C. PROCEDURE, SERVICE, OR SUPPLIER (CPT/HCPCS) | D. DIAGNOSIS (ICD-9-CM) | E. CHARGE | F. ICD-9-CM | G. ICD-9-CM | H. PROVIDER NUMBER (NPI) |
|--|---------------------------|--|-------------------------|-----------|-------------|-------------|--------------------------|
| 1  |                           |  |                         |           |             |             | NPI                      |
| 2  |                           |  |                         |           |             |             | NPI                      |
| 3  |                           |  |                         |           |             |             | NPI                      |
| 4  |                           |  |                         |           |             |             | NPI                      |
| 5  |                           |  |                         |           |             |             | NPI                      |
| 6  |                           |  |                         |           |             |             | NPI                      |

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO 27. ACCOUNT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE 29. AMOUNT PAID 30. REVERSED FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (NPI) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P.I.F. ( )

# Date Last Seen and Attending Physician

- Routine foot care
  - CPT/HCPCS G0127, 11055, 11056, 11057, 11719, 11720 and 11721
- Certain conditions require a patient to be under the care of a primary physician
  - **Claims must indicate the date last seen and NPI of attending physician**
  - Line item 19 or electronic equivalent
- Systemic condition modifiers: Q7, Q8 or Q9

# Steps to Successfully Check LCDs

- Referral, DLS and NPI of attending physician requirements
  - [CMS-1500 Claim Form Completion Instructions](#)
- Routine foot care L33636/A57759
  - [Local Coverage Determinations](#)



Reducing Claim Rejections for Place  
Where Services are Rendered (1%)



PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SCHIP/CHIP (LAW) OTHER YES INSURED'S ID. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. & Street) 6. PATIENT RELATIONSHIP TO INSURED (Set  Spouse  Child  Other) 7. INSURED'S ADDRESS (No. & Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

ZIP CODE TELEPHONE (3-Digit Area Code) ZIP CODE TELEPHONE (3-Digit Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PRESENT CONDITION RELATED TO: 11. INSURED'S POLICY OR GROUP OR FCDA NUMBER

12. OTHER INSURED'S POLICY OR GROUP NUMBER 13. EMPLOYMENT (Current or Former) a.  YES  NO b. AUTO ACCIDENT? PLACE (State)  YES  NO c. OTHER ACCIDENT?  YES  NO 14. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX 15. OTHER CLAIM ID (Designated by NUCC) 16. INSURANCE PLAN NAME OR PROGRAM NAME 17. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO (If yes, complete items 18, 19, and 20)

18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or reimbursement benefits either to myself or to the party who accepts assignment of benefits. 19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE SIGNED

21. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM, DD, YY) QUAL 22. OTHER DATE (MM, DD, YY) QUAL 23. DATE PATIENT WANTED TO WORK (MM, DD, YY) OCCUPATION

24. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17A, 17B, NP) 25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM, DD, YY) (MM, DD, YY) TO (MM, DD, YY)

26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 27. OUTSIDE LAB?  YES  NO 28. CHARGES

29. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM or ICD-10-CM code) 30. PRESCRIPTION CODE ORIGINAL RFP NO 31. PRIOR AUTHORIZATION NUMBER

32. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER (Specify Unusual Circumstances) D. DIAGNOSIS (ICD-9-CM) E. CHARGES F. DAYS OF SERVICE G. H. I. J. PROVIDING PROVIDER ID #

1 2 3 4 5 6

33. FEDERAL TAX ID NUMBER 34. PATIENT'S ACCOUNT NO 35. ACCOUNT ASSIGNMENT?  YES  NO 36. TOTAL CHARGE 37. AMOUNT PAID 38. RESERVE FOR NUCC USE

39. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials (I certify that the statements on this invoice apply to this bill and are true to the best of my knowledge)) 40. SERVICE FACILITY LOCATION INFORMATION 41. BILLING PROVIDER INFO & PAF ( )

# Place of Service

- Provide place where services are rendered
- Complete name, address, ZIP code where services were furnished
  - Hospital
  - Clinic
  - Laboratory
  - Patient's home
  - Physician's office
  - Diagnostic tests subject to anti-markup
- Line Item 32 or electronic equivalent

# Steps to Successfully Check Place of Service

- [Medicare Place of Service Code Set and Descriptions](#)
- [CMS-1500 Claim Form](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)





Reducing Claim Rejections for  
Services Not Payable Under NGS  
Jurisdiction (3%)

# Place Where Services are Rendered

- Line item 32
  - If services were furnished in hospital, clinic, laboratory or any facility or physician's office, enter the name, address and ZIP code where the patient received care
  - Only one name, address and ZIP code may be entered in the block
  - P.O. Box is not acceptable
  - Do not include telephone numbers, commas, periods or other punctuation in address
  - Enter a space between city and state postal code
  - Provider must be enrolled in MAC for location from which they perform service

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PCIA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER 76. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. & Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. & Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PRESENT CONDITION RELATED TO 11. INSURED'S POLICY OR GROUP OR FCDA NUMBER

4. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT (Current or Previous) 4. INSURED'S DATE OF BIRTH (MM DD YY) SEX

5. RESERVED FOR NUCC USE b. AUTO ACCIDENT? (PLACE CHECK) 5. OTHER CLAIM ID (Designated by NUCC)

6. RESERVED FOR NUCC USE c. OTHER ACCIDENT? 6. INSURANCE PLAN NAME OR PROGRAM NAME

4. INSURANCE PLAN NAME OR PROGRAM NAME 10c. CLAIM CODES (Designated by NUCC) 6. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (Please complete items 9, 10, and 10c)

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of all medical or other information necessary to process this claim. I also request payment of government benefits other than injury or death benefits to the party and accept assignment below. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL 15. OTHER DATE (MM DD YY) QUAL 16. DATE OF CURRENT CHANGE TO WORK IN CURRENT OCCUPATION (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. 17c. 17d. 17e. 17f. 17g. 17h. 17i. 17j. 17k. 17l. 17m. 17n. 17o. 17p. 17q. 17r. 17s. 17t. 17u. 17v. 17w. 17x. 17y. 17z. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO 21. CHARACTERS

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM code in the below box) (ICD NO.) 22. PHARMARKET CODE ORIGINAL RFP NO

A. B. C. D. E. F. G. H. I. J. K. L. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE From To B. C. PLACE OF SERVICE (Specify Universal Organization) D. PROVIDER'S IDENTIFICATION NUMBER E. DIAGNOSIS F. HONORARIUM G. CHARGE H. DAYS OF SERVICE I. HCP IDENTIFICATION NUMBER J. C. I.D. NUMBER K. PROVIDING PROVIDER ID #

1 2 3 4 5 6

25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? (BY SUPPLIER USE ONLY) 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVED FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials to certify that the statements on this cover apply to this bill and are made a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & P.H.F. ( )



# Durable Medical Equipment MAC

- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
  - HCPCS code and modifier combinations
    - Example HCPCS A, B, E, J, K, L, Q and V
  - Part B services processed by DME Regional Contractors
  - Item 24D on CMS-1500 or the electronic equivalent
- Do not send these claims to NGS Medicare

# Steps to Successfully Check Jurisdictions

- Know what codes are billable to DME MAC
- [DME MAC Jurisdiction A](#)
  - CT-MA-ME-NH-NY-RI-VT
- [DME MAC Jurisdiction B](#)
  - IL-MN-WI
- [CMS IOM Pub 100-04, Medicare Claims Processing Manual, Chapter 12-Physicians/Nonphysician Practitioners](#)





# Reducing Claim Rejections for CPT and HCPCS Codes and Modifiers (20%)





# Have Current Code Books

- CPT
  - Numeric coding system that describes the services and procedures provided by a physician
- HCPCS
  - Alpha numeric coding system used by a physician to report services
- ICD-10-CM code books
  - Used to select appropriate diagnosis codes

# Medicare Physician Fee Schedule

The screenshot displays the National Government Services website interface. At the top, there is a blue header with the 'national government SERVICES' logo on the left and a search icon on the right. Below the header, the main content area is divided into six white cards with blue icons and text. The 'Fee Schedules' card is highlighted with a black border. The cards are arranged in a 2x3 grid:



- Medical Policies**: Find LCDs and related billing and coding articles
- Enrollment**: Getting started, after you enroll, and revalidating your enrollment
- Fee Schedules**: Code pricing search, payment systems, limits, and fee schedule lookup
- Claims and Appeals**: Learn about claims, top errors, fees, MBI and appeals
- Overpayments**: Repayment schedules, and post-pay adjustment
- Medicare Compliance**: Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

# Fee Schedule Lookup – Types

The screenshot shows the 'FEE SCHEDULE LOOKUP' page on the National Government Services website. The page includes a navigation bar with 'HOME', 'EDUCATION', 'RESOURCES', 'EVENTS', 'ENROLLMENT', and 'APPS'. Below the navigation, there is a breadcrumb trail 'Resources > Tools & Calculators' and a search icon. The main heading is 'FEE SCHEDULE LOOKUP'. Below this, there is a sub-heading 'Fee Schedule Lookup' and a instruction: 'To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.' The main content area features a form with a label 'Select a Fee Schedule.' and a red asterisk. A drop-down menu is open, showing the following options: '--Select Fee Schedule--', 'ASC Fees', 'Ambulance', 'Anesthesia Conversion Factor', 'CP/CSW', 'Flu/PPV/Hepatitis', 'Home Infusion Therapy Services (HITS)', 'Medicare Physician Fee Schedule Pricing', and 'Opioid Treatment Program (OTP)'.

# Fee Schedule Lookup

NCSCConnex [Subscribe for Email Updates](#) [Part B Provider in Massachusetts \( JK \)](#) ▼

 [HOME](#) [EDUCATION](#) ▼ [RESOURCES](#) ▼ [EVENTS](#) [ENROLLMENT](#) [APPS](#) ▼ 

[Resources](#) > [Tools & Calculators](#)

## FEE SCHEDULE LOOKUP

### Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

|                          |   |
|--------------------------|---|
| Select a Fee Schedule: * | <input type="text" value="Medicare Physician Fee Schedule Pricing"/>                  |
| Result Type: *           | <input type="radio"/> Full Fee Schedule<br><input type="radio"/> Specific To Fee Code |
| Date of Service: *       | <input type="text" value="mm/dd/yyyy"/>   |
| Procedure Code: *        | <input type="text"/>  |
| Region: *                | <input type="text" value="--Select Region--"/>  |

# Fee Schedule Lookup – Regions

To initiate a search, select a fee schedule type from the drop-down

Select a Fee Schedule: \*

Result Type: \*

Date of Service: \*

Procedure Code: \*

Region: \*

--Select Region--

- Connecticut
- Illinois (area 12)
- Illinois (area 15)
- Illinois (area 16)
- Illinois (area 99)
- Maine (area 03)
- Maine (area 99)
- Massachusetts (area 01)
- Massachusetts (area 99)
- Minnesota
- New Hampshire (area 40)
- New York (area 01)
- New York (area 02)
- New York (area 03)
- New York (area 04)
- New York (area 99)
- Rhode Island (area 01)
- Vermont (area 50)
- Wisconsin

--Select Region--

Search



# Locality/Area and County Information

| IL  | MA                                | ME                     | NY  |
|---|-----------------------------------|------------------------|---|
| 12-Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, Washington locality Payment Jurisdiction | 01-Middlesex, Norfolk and Suffolk | 03-York and Cumberland | 01-Manhattan  |
| 15-DuPage, Kane, Lake, Will   | 99- All other Counties            | 99-All other Counties  | 02-Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester |
| 16-Cook   |                                   |                        | 03-Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster |
| 99-All other Counties   |                                   |                        | 04-Queens   |
|   |                                   |                        | 99-All other Counties   |

# Fee Schedule Example

## Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

**Note:** If your search does not display the fee schedule or effective date (range) you enter, access the CMS website to view and download [National Fee Schedules](#).

Select a Fee Schedule: \*

Medicare Physician Fee Schedule Pricing

Result Type: \*

Full Fee Schedule

Specific To Fee Code

Date of Service: \*

11/19/2024

Procedure Code: \*

33535

Region: \*

Massachusetts (area 01)

Search

# Fee Schedule Pricing Files

## Medicare Physician Fee Schedule Pricing Fee Schedule

| <u>Procedure Code</u> | <u>Effective Date</u> | <u>State/Territory</u> | <u>Locality</u> | <u>Short Description</u> |
|-----------------------|-----------------------|------------------------|-----------------|--------------------------|
| 33535                 | 03/09/2024            | 14212                  | 01              | Cabg arterial three      |

### Non-OPPS Capped Payment Rates (NON-OPPS)

| <u>Modifier</u> | <u>NON FAC PAR</u> | <u>NON FAC NON PAR</u> | <u>NON FAC LC</u> | <u>FAC PAR</u> | <u>FAC NON PAR</u> | <u>FAC LC</u> |
|-----------------|--------------------|------------------------|-------------------|----------------|--------------------|---------------|
| (Details)       | 2525.46            | 2399.19                | 2759.07           | 2525.46        | 2399.19            | 2759.07       |

# Database Policy Indicators

FEES

Payment Calculation

Policy Indicators

| <u>Non-OPPS Capped Payment Rates (NON-OPPS)</u> |                          |                             |                                |                                  |                                 |               |
|---|--------------------------|-----------------------------|--------------------------------|----------------------------------|---------------------------------|---------------|
| <u>Modifier</u>                                 | <u>NON FAC PAR</u>       | <u>NON FAC NON PAR</u>      | <u>NON FAC LC</u>              | <u>FAC PAR</u>                   | <u>FAC NON PAR</u>              | <u>FAC LC</u> |
| (Details)                                       | 2525.46                  | 2399.19                     | 2759.07                        | 2525.46                          | 2399.19                         | 2759.07       |
| <b>Modifier Selected: (blank)</b>               |                          |                             |                                |                                  |                                 |               |
| <u>Status</u>                                   | <u>Conversion Factor</u> | <u>Update Factor</u>        | <u>Work RVU</u>                | <u>FAC PE RVU</u>                | <u>NON FAC PE RVU</u>           |               |
| A   | 33.2875                  | 1.0000                      | 44.75                          | 16.48                            | 16.48                           |               |
| <u>Malpractice RVU</u>                          | <u>Work GPCI</u>         | <u>Practice GPCI</u>        | <u>Malpractice GPCI</u>        | <u>Reduced Therapy Amt</u>       | <u>Endoscopic Base</u>          |               |
| 10.64   | 1.042                    | 1.197                       | 0.894                          | 0.00                             |                                 |               |
| <u>Global Surgery</u>                           | <u>Facility Pricing</u>  | <u>PC/TC</u>                | <u>Preoperative Percentage</u> | <u>Interoperative Percentage</u> | <u>Postoperative Percentage</u> |               |
| 090   | 1                        | 0                           | 09.00%                         | 82.00%                           | 09.00%                          |               |
| <u>Multiple Surgery</u>                         | <u>Bilateral Surgery</u> | <u>Assistant At Surgery</u> | <u>Two Surgeons</u>            | <u>Team Surgery</u>              |                                 |               |
| 2   | 0                        | 2                           | 0                              | 0                                |                                 |               |



# Policy Indicators

- Procedure status indicators
- Global surgery
- Facility pricing
- Preoperative
- Interoperative
- Postoperative
- Multiple surgery
- Bilateral surgery
- Assistant at surgery
- Two surgeons
- Team surgery
- Use References: [Fee Schedule Lookup Details](#)



# Not Otherwise Classified or Unlisted Codes and Documentation

- An unlisted code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code
- Unlisted codes should be reported only if no other specific codes adequately describe the procedure or service
- Consider finding a CPT code that best describes service/procedure using the reduced service modifier 52
- Service/procedure(s) should be adequately documented in your medical record and submitted with each claim
  - Paper or electronic media claims
- Medicare allowable amounts are not established; therefore, allowance is based on the supporting documentation

# Modifiers

- Two types of modifiers in MCS
  - CPT – numeric
  - HCPCS – letter and numeric
- Pricing modifiers
  - First field
- Statistical/informational modifiers
  - Second field
- Always enter pricing modifiers before statistical/informational modifiers

# Modifiers – List Not All Inclusive

- Pricing Modifiers
  - Anesthesia modifiers
    - AA, AD, QK, QW, QX, QY, QZ
  - Assistant at surgery modifiers
    - AS, 80, 81, 82
  - Diagnostic modifiers
    - CT, FX, TC, 26
  - Evaluation and management
    - 24, 25, 57
  - Surgery modifiers
    - 50, 62, 66, 73, 74, 78
  - Shared care
    - 54, 55
- Statistical/informational modifiers
  - Coronary artery modifiers
    - LC, LD, LM, RC, RI
  - Eye lid modifiers
    - E1, E2, E3, E4
  - Finger modifiers
    - FA, F1, F2, F3, F4, F5, F6, F7, F8, F9
  - Toe modifiers
    - TA, T1, T2, T3, T4, T5, T6, T7, T8, T9
  - Side of body modifiers
    - LT, RT

# Steps to Successfully Check CPT/HCPCS

- [MPFS available on our Fee Schedule Lookup page](#)
- [Fee Schedule Assistance](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual](#)
  - [Chapter 23 “Fee Schedule Administration and Coding Requirements”](#)
  - [Chapter 26 “Completing and Processing Form CMS-1500 Data Set”](#)
- [Unlisted and Not Otherwise Classified Procedure Codes](#)
- [Education > Medicare Topics > Billing](#)
- [Education > Manuals and Guides > Medicare Part B 101 Manual](#)



# Claim Reminders

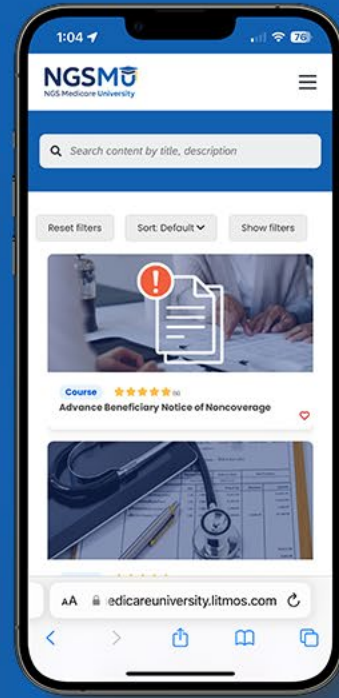
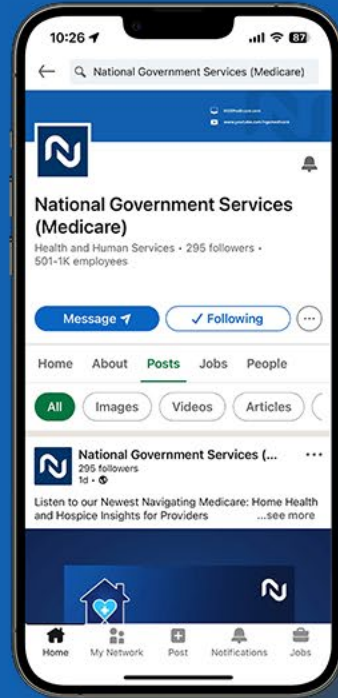
- Resubmit, redetermination or reopen
- Resubmit
  - Unprocessable denials
- Redetermination
  - Medical necessity claim denials
- Reopen
  - Minor clerical errors or omissions
- Reopenings for Minor Errors and Omissions





# Questions?

Thank you!



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Educational Videos

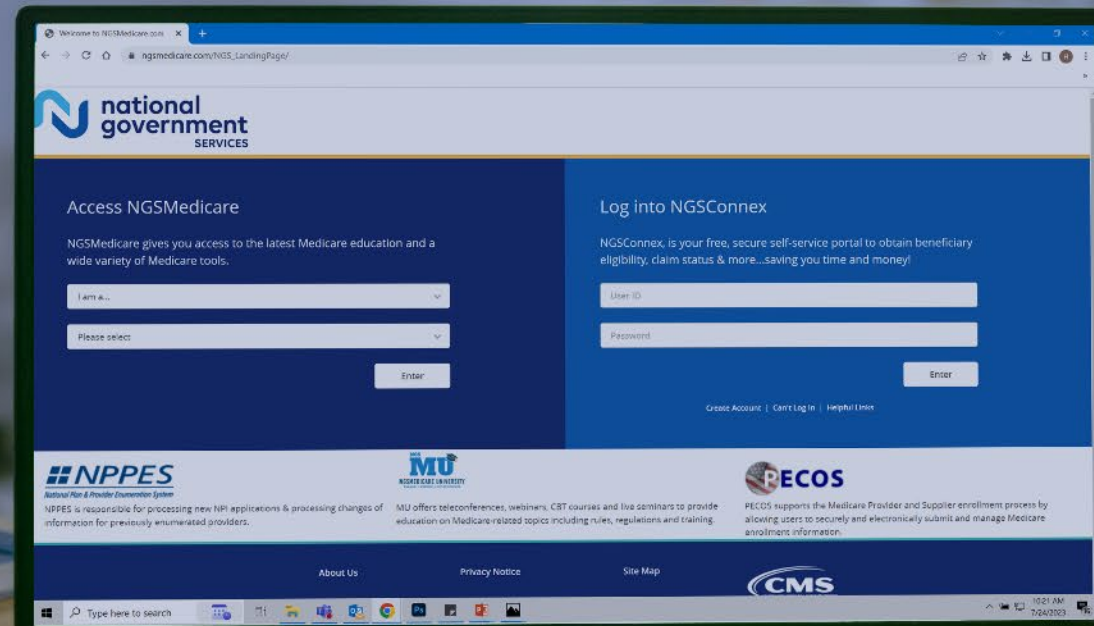


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