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National Government Services

Using FISS DDE to Adjust or Cancel Medicare Claims

9/28/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- Advise providers when/how to adjust claims through the FISS DDE online system
  - Including adjusting claims due to an MSP-related Issue
- Provide simple steps for completing a claim cancel through FISS DDE

Agenda

- Claim adjustments
  - How to complete a claim adjustment
    - Demonstration of claim adjustment process
  - Adjusting a claim due to a MSP-related issue
    - Preparing MSP-Related Adjustments Chart
- Claim cancels
  - How to complete a claim cancel
    - Demonstration of claim cancellation process
- Questions and answers

What You Need to Know About Claim Adjustments

Adjustments - Defined

- Adjustments are submitted to **change details** on processed claim
  - **Report services not previously billed**
  - Delete services billed in error
  - Correct DOS
  - Add/change units
  - Correct diagnosis codes
  - Change MSP rejected claim to primary

Which Claims Can Be Adjusted

- Adjustments only apply to claims in these S/LOCs
  - P/B9997 (Processed)
  - R/B9997 (Rejected) (limited use only)
    - Only rejected claims that have posted to CWF are eligible for adjustment
      - Example of rejections that post to CWF: Timely filing rejections
      - Example of rejections that do not post to CWF: Eligibility rejections

Reviewing the Tape-to-Tape Flag

- Indicates whether claim has posted to CWF
  - Log in to FISS DDE
  - Access Inquiries sub-menu (01) Claim Summary option (12)
  - Search for and select claim
  - Review claim page 02 - MAP171D
  - Look for “TPE-TPE” field
    - If value is “blank,” claim has posted to CWF
      - Must adjust claim to make changes
    - If value is “X,” claim did not post to CWF
      - Must resubmit new claim for processing

Reviewing the Tape-to-Tape Flag

```
MAP171D   PAGE 02  NATIONAL GOVERNMENT SERVICES #14013 UAT   ACMFA781 11/18/20
MXG9282   SC              INST CLAIM ADJUSTMENT             A20204DP 13:37:16
DCN [redacted]  MID              RECEIPT DATE 111820  TOB 137
STATUS R  LOCATION B9997     TRAN DT 000000    STMT COV DT 051120   TO 051120
PROVIDER ID                 BENE NAME
NONPAY CD     GENER HARDCPY       MR INCLD IN COMP          CL MR IND
TPE-TO-TPE X  USER ACT CODE       WAIV IND    MR REV URC    DEMAND
REJ CD        MR HOSP RED         RCN IND     MR HOSP-RO    ORIG UAC
MED REV RSNS
OCE MED REV RSNS
   1    HCPC/MOD IN    SERV                            -----REASON-CODES------
 REV  HCPC MODIFIERS   DATE  COV-UNT   COV-CHRG   ADR
0306 87077            051120       1      89.00   FMR
ORIG                     ORIG REV         MR      ODC
OCE OVR 0 CWF OVR   NCD OVR   NCD DOC   NCD RESP 1 NCD#          OLUAC
        NON       NON    DENIAL OVER ST/LC  MED  ------------ANSI------------
LUAC  COV-UNT   COV-CHRG  REAS  CODE OVER   TEC  ADJ  GRP ------REMARKS------




TOTAL                          LINE ITEM REASON CODES
      PROCESS COMPLETED  ---   PLEASE CONTINUE
    PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

Claim Status/Location Reminder

- RTP (T/B9997) claims can be corrected, but cannot be adjusted or cancelled
- Denied (D/B9997) claims can be appealed, but cannot be adjusted or cancelled
- Suspended (S) claims or those on the “payment floor” (P/B9996) are not finished processing yet and cannot be adjusted or cancelled

Using FISS DDE to Adjust a Claim

1. Gather required information
2. Access processed/rejected claim
3. Make claim adjustments
   - Claim change reason code
   - Claim lines
   - Adjustment reason code
   - Remarks
4. Submit and verify claim adjustment

Step 1: Gather Required Information

- Claim change reason code chart
  - Describes reason why claim is changing
  - Two-digit alpha-numeric code
    - Entered on claim page 1 (condition code)
- Adjustment reason code
  - Describe reason for adjustment
  - Two-digit alpha code
    - Entered on claim page 3 in adjustment reason code field

Step 2: Access the Claim

- Log into FISS DDE
- Select Claims Correction Menu (option 03)
- Select option from Claim and Attachments Correction Menu
  - Based on processed/rejected claim type
    - Inpatient – 30
    - Outpatient – 31
    - SNF – 32
    - Home Health – 33
    - Hospice – 35

Step 2: Access the Claim

- Enter MBI and DOS
  - List of processed claims will be displayed
  - To view list of rejected claims that can be adjusted, overwrite ‘P’ in status field with ‘R’
- Select claim to be adjusted by placing ‘U’ in SEL field
  - Claim opens at page 1
  - TOB automatically changes to XX7
  - System pulls in DCN from claim to be adjusted

Step 3: Make Adjustments to Claim

- On claim page 1, enter claim change reason code in CC field
  - Only one claim change reason code should be reported per adjustment claim
  - If more than one applies, choose the most appropriate claim change reason code

Claim Change Reason Codes (Condition Codes) for Adjustments

Reason Code	Description
D0 (zero)	Changes to service dates
D1	Changes to charges
D2	Changes to revenue/HCPCS/HIPPS rate codes
D3	Second or subsequent interim PPS bill
D4	Changes in ICD-10-CM diagnosis/procedure code • Use for IP acute care hospital, LTCH, IRF, and SNF
D7	Change to Medicare primary, conditional, or cost-avoided claim to make Medicare secondary
D8	Change to MSP claim to make Medicare primary
D9	Any other change to MSP/conditional claim Change to cost-avoided claim to make Medicare primary Any other change (Remarks required)
E0 (zero)	Change in patient status

Step 3: Make Adjustments to Claim

- When reason for adjustment is to make changes to claim lines, make appropriate claim adjustments on claim page 2
  - Change units, codes, rates; recalculate total charges

Avoid a Common Adjustment Error

- When claims reject, charges are placed into the "NCOV CHARGES" (noncovered charges) field on claim page 02
- Claim lines must be deleted and added as new covered charge lines when claim is adjusted
- Be sure the 0001 Totals line is re-added and calculated appropriately

Delete and Rekey Claim Lines

- Delete revenue code lines by placing a ‘D’ on the first position of the revenue code
  - Press the <Home> key
  - Press the <Enter> key
    - This will delete the entire revenue code line
- Add new charges by first deleting Total Charge (0001) line, adding new line(s)
- Make sure Total Charge line (0001) added and recalculated

Step 3: Make Adjustments to Claim

- On claim page 3, enter adjustment reason code
  - Listing of adjustment reason codes located in FISS DDE Inquiry menu (01) Adjustment Reason Code file (16)

FISS Adjustment Reason Code File

```
 MAP1821            NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 11/18/20
 MXG9282   SC           ADJUSTMENT REASON CODES INQUIRY       A20204DP 13:52:28
                                SELECTION SCREEN          MNT: MXG9282  111820
 CLAIM TYPES:
 I = INPATIENT/SNF, O = OUTPATIENT, H = HOME HEALTH/CORF, A = ALL CLAIMS
 PLAN CODE: 1        REASON CODE: _
S PC RC HC TYPE                    NARRATIVE
  1  BF BF H HHPPS FINAL NOT RECEIVED
  1  BL BL A This overpayment is a result of a claim being processed with
  1  BM TB A ORIGINALL PROCESSED A SBLACK LUNG, NOW MAKE MEDICARE PRIME.
  1  CA CA I This claim adjustment is a result of the cost outlier approval.
  1  CB CB A This overpayment is the result of the credit balance report.
  1  CC CC A This overpayment is a result of the change in the charge amount.
  1  CD CD I This overpayment is a result of a Quality Improvement Organizati
  1  CE OT A REVENUE CODE CORRECTION.
  1  CF CF A This overpayment is a result of a change in coverage.
  1  CH OT O CORRECTION OF OUTPATIENT CASH DEDUCTIBLE.
  1  CI OT A CORRECTION OF PATIENT CASH DEDUCTIBLE.
  1  CN OT I CHANGE IN COV TO NONCOV/NONCOV TO COV DAYS
  1  CO CO I This overpayment is a result of a Quality Improvement Organizati
  1  CP CP I This overpayment is a result of a partially approved cost outlie
  1  CR CR A A claim reconsideration adjustment has been processed.
       PROCESS COMPLETED  ---   PLEASE CONTINUE
 PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Step 3: Make Adjustments to Claim

- On claim page 4, enter Remarks
  - For any situation where an adjustment requires some explanation
  - When claim change reason code D9 is used, Remarks are mandatory
    - CC D9 causes claim to kick out to manual processing and remarks will be read by a claims reviewer
  - Remarks otherwise not mandatory for adjustments

Step 4: Submit & Verify Claim Adjustment

- Review changes to ensure accuracy
- Hit <F9/PF9> to resubmit claim for processing
- Verify that claim was stored correctly by going into Inquiries submenu (Option 01) and choosing Claims Summary option (Menu 12)
  - Available next day after updating claim (<F9/PF9>)
  - Key patient's MBI and from/through dates of adjustment claim
  - Adjustment should appear in 'S' Location
  - TOB = XX7

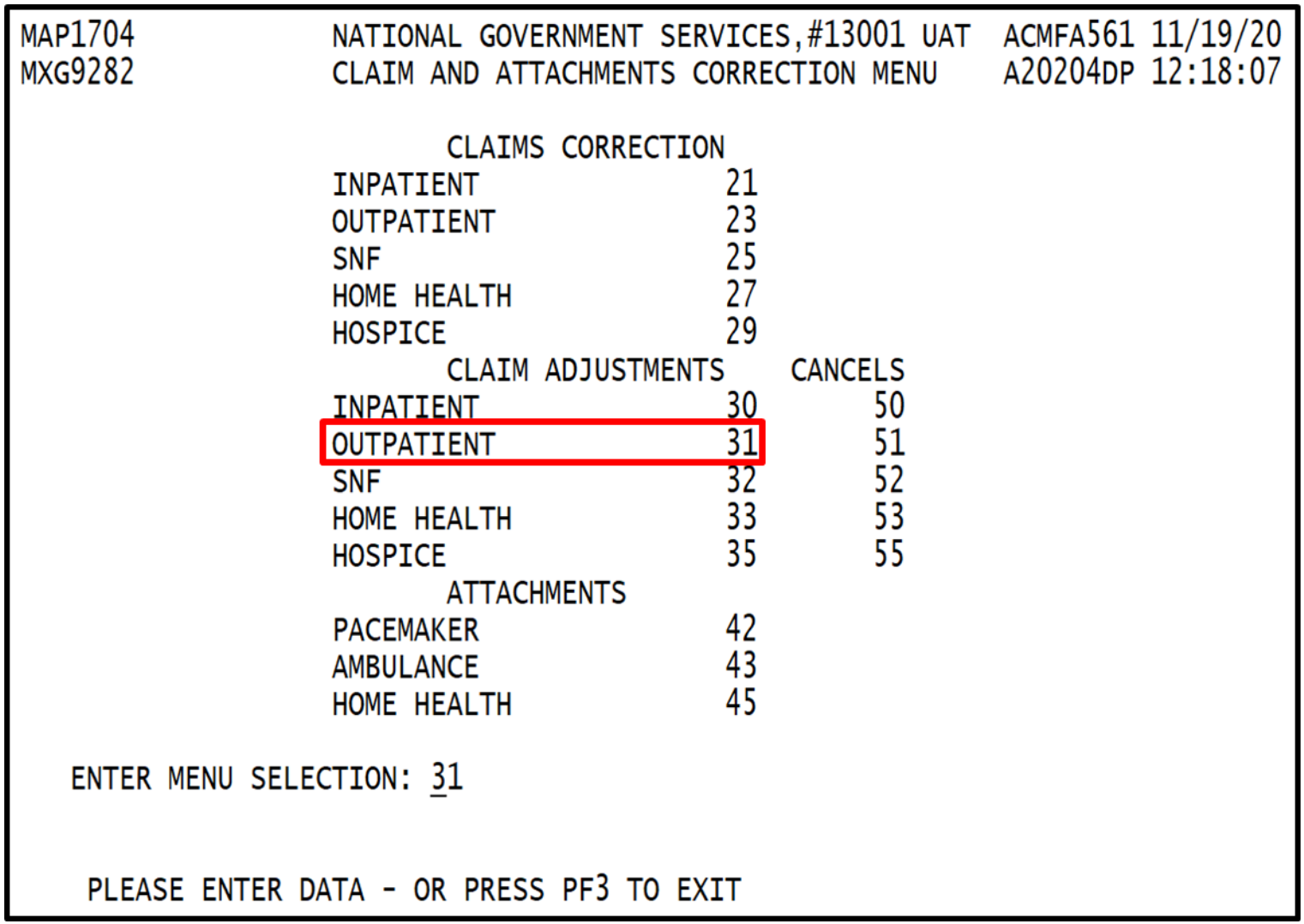
FISS DDE Adjustment Demonstration: Adding Charges to a Claim

- Additional services need to be added to processed outpatient claim
  - Claim was processed without CPT code G0449
- Claim must be adjusted

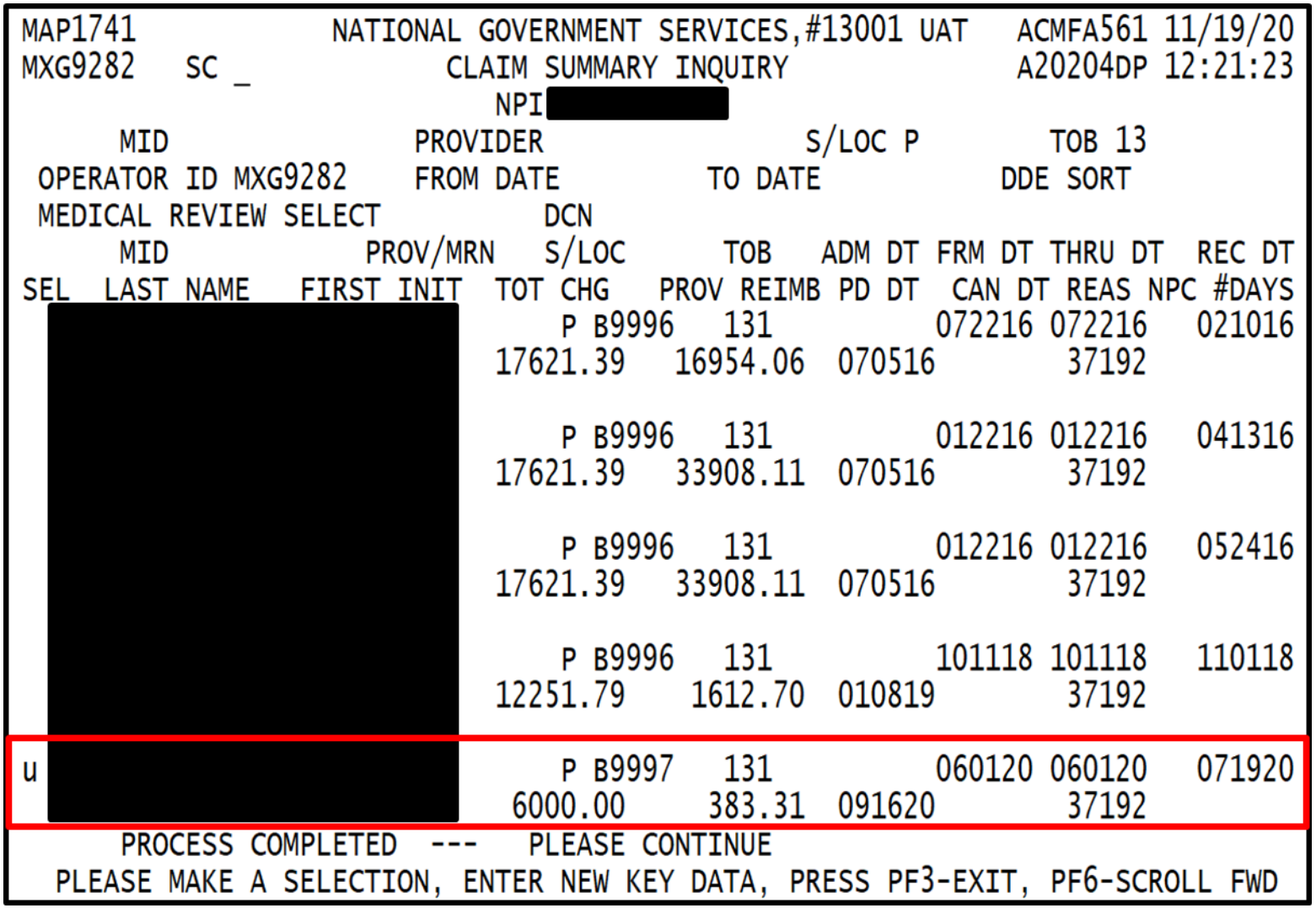
Step 1: Gather Required Information

- Reason for adjustment
  - Change in charges
- Appropriate claim change reason code
  - D1
- Appropriate adjustment reason code
  - CE

Step 2: Access the Claim



Step 2: Access the Claim



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                              NPI[redacted]
      MID                PROVIDER                 S/LOC P        TOB 13
 OPERATOR ID MXG9282     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
[redacted]                        P B9996   131          072216 072216   021016
                             17621.39   16954.06  070516        37192

                                  P B9996   131          012216 012216   041316
                             17621.39   33908.11  070516        37192

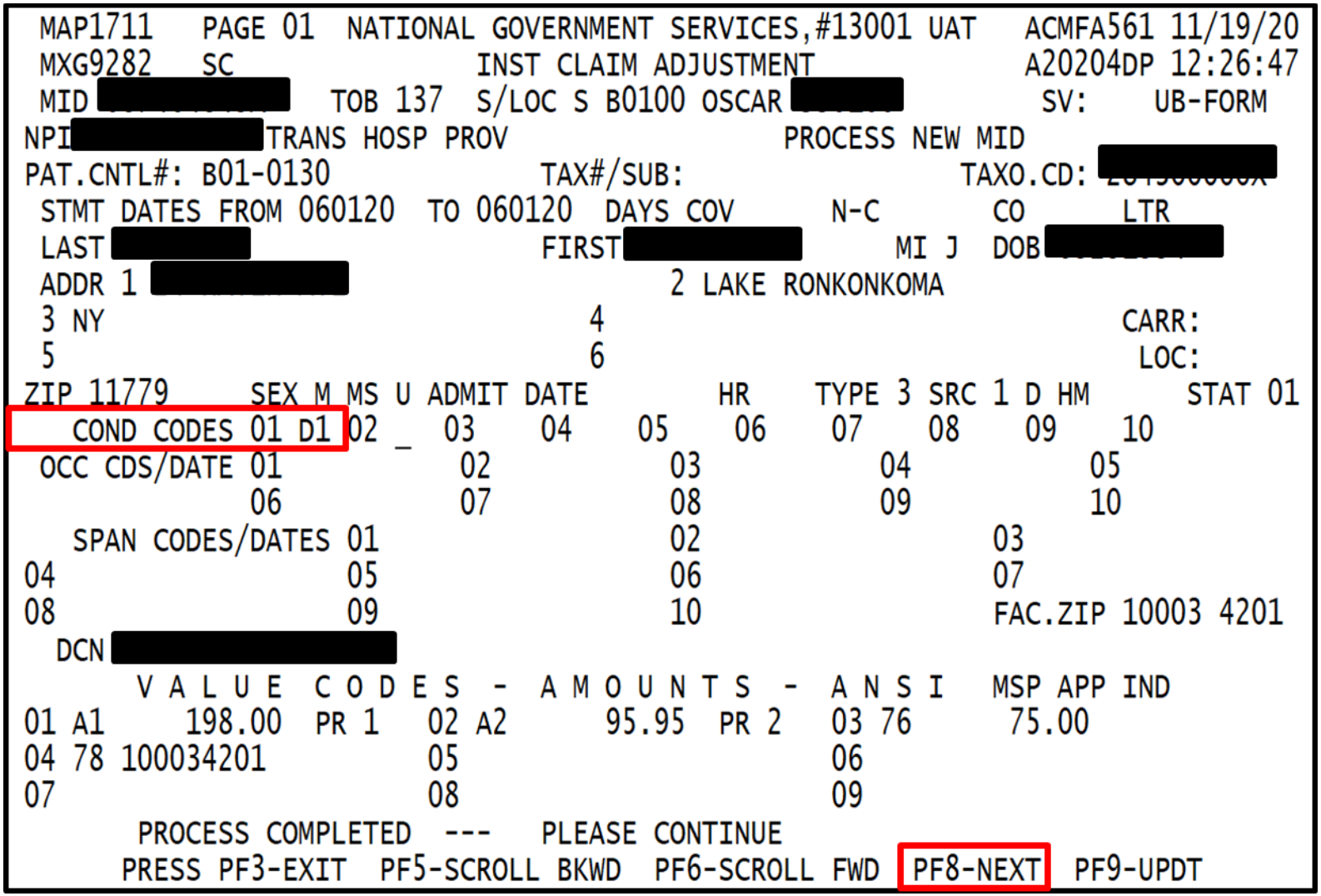
                                  P B9996   131          012216 012216   052416
                             17621.39   33908.11  070516        37192

                                  P B9996   131          101118 101118   110118
                             12251.79    1612.70  010819        37192

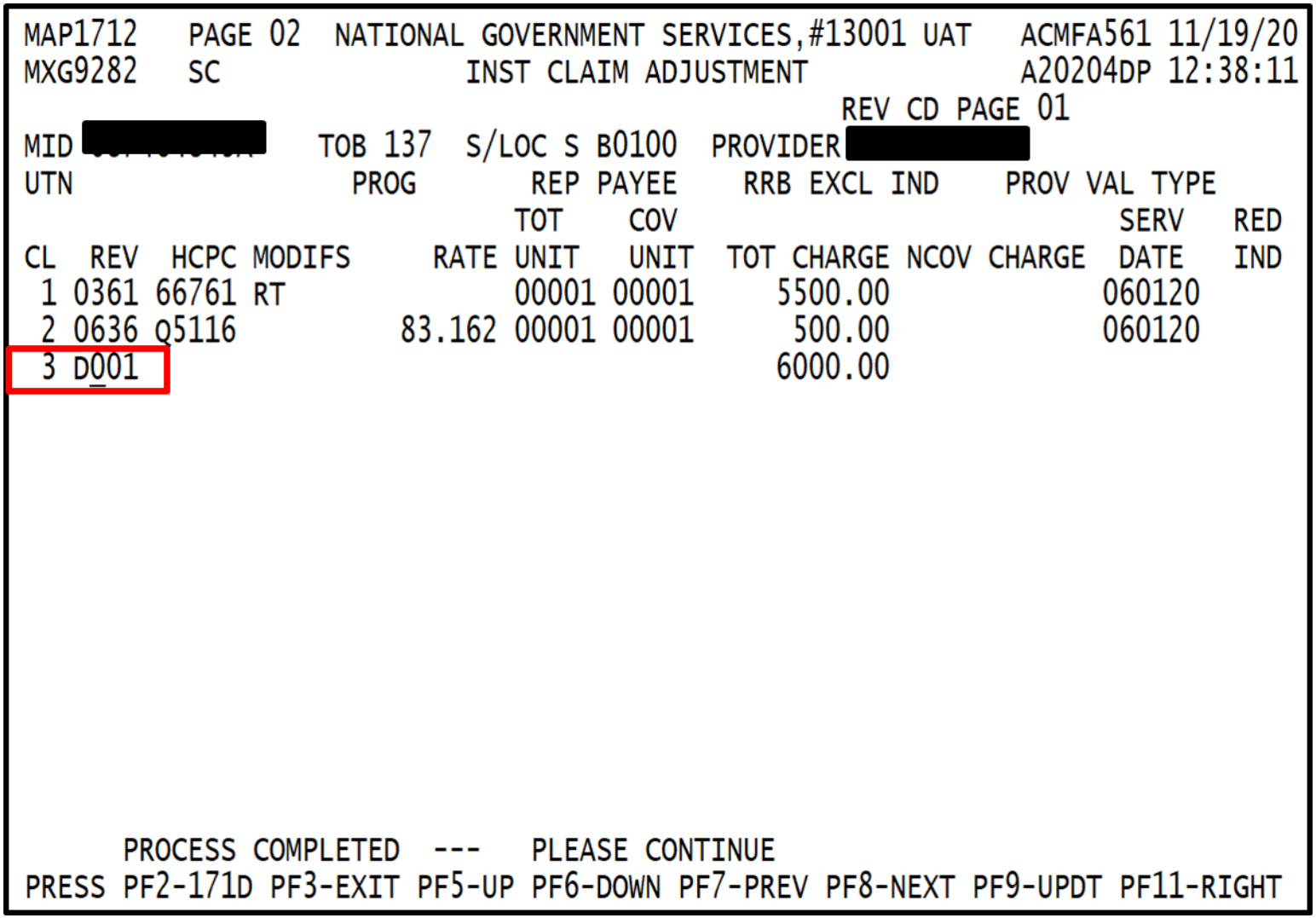
u[redacted]                       P B9997   131          060120 060120   071920
                              6000.00     383.31  091620        37192

      PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

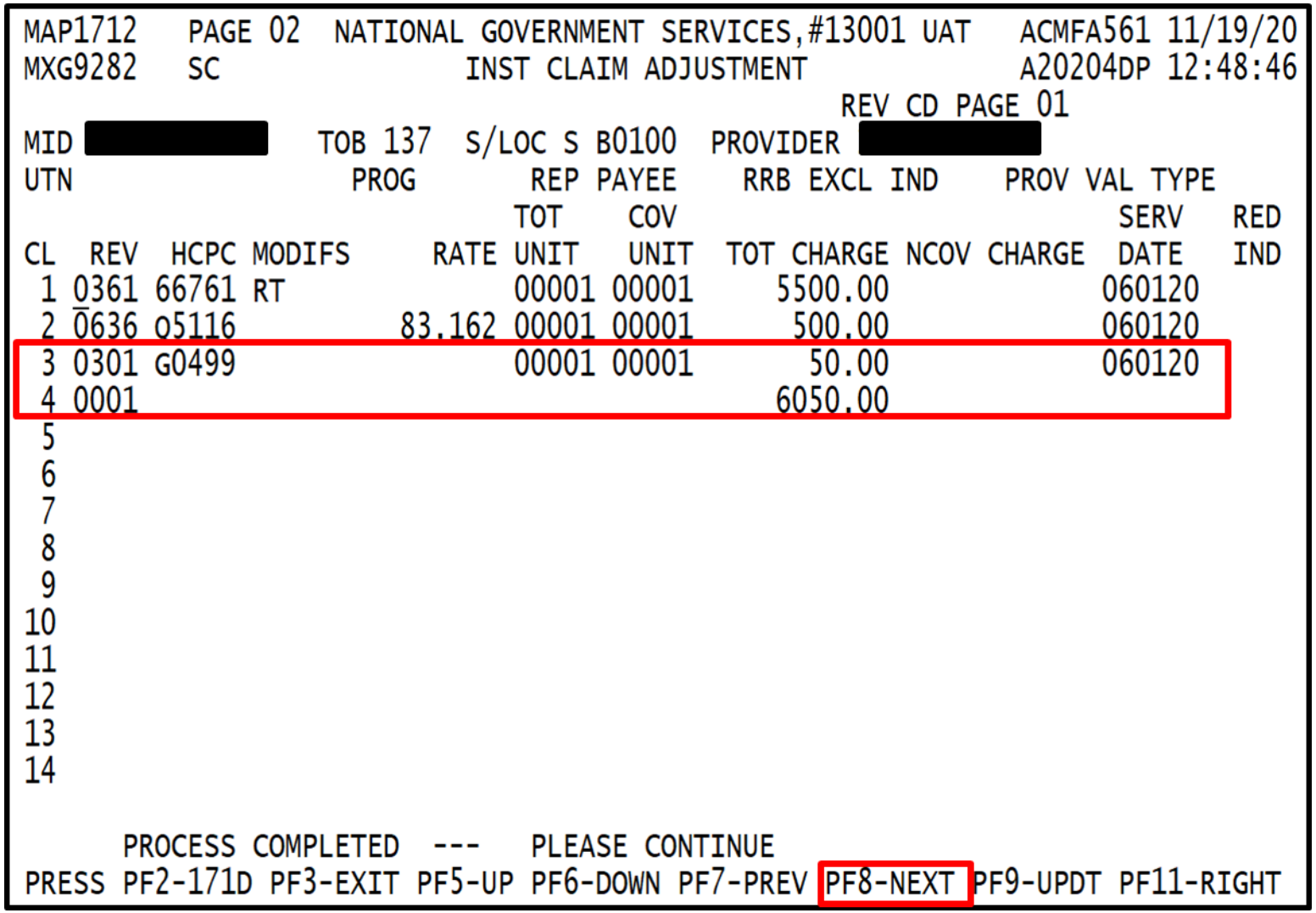
Step 3: Add Claim Change Reason Code



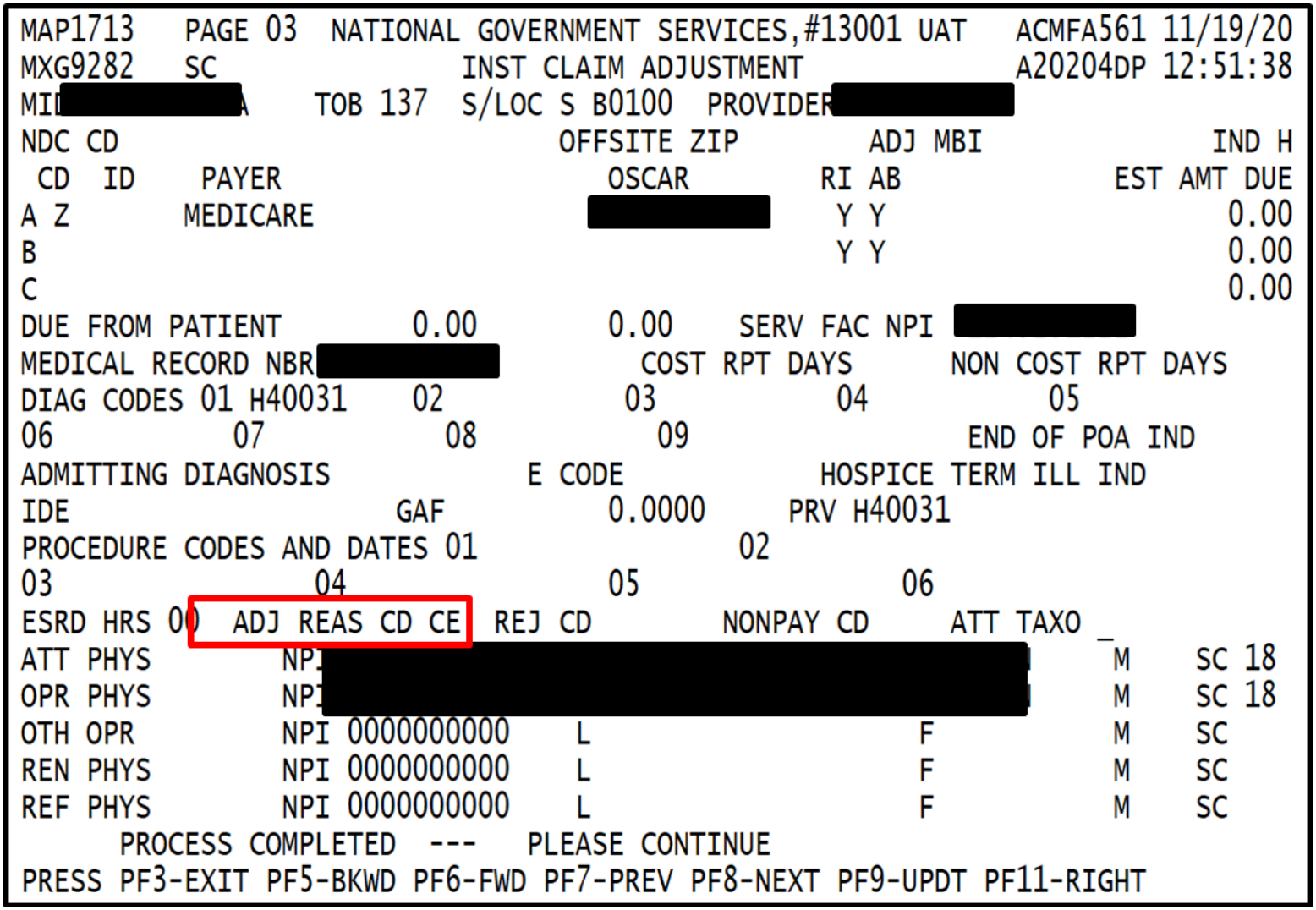
Step 3: Delete 0001 Totals Line



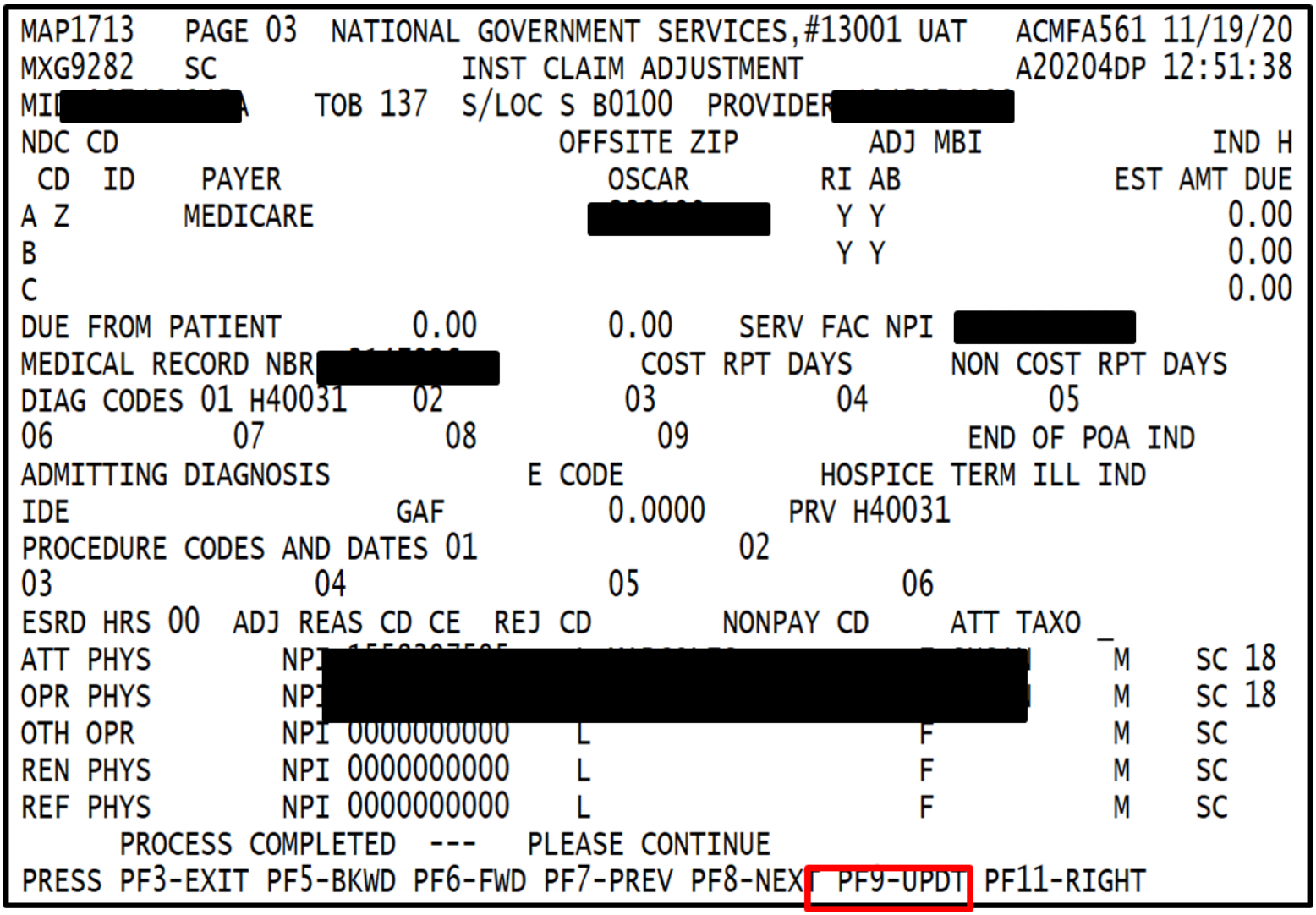
Step 3: Add New Line, Add 0001 Line



Step 3: Add Adjustment Reason Code



Step 4: Submit Claim Adjustment



```
MAP1713   PAGE 03  NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 11/19/20
MXG9282   SC                INST CLAIM ADJUSTMENT           A20204DP 12:51:38
MI[redacted]A    TOB 137  S/LOC S B0100  PROVIDER[redacted]
NDC CD                              OFFSITE ZIP        ADJ MBI            IND H
 CD  ID    PAYER                      OSCAR        RI AB             EST AMT DUE
A Z       MEDICARE                   [redacted]      Y Y                  0.00
B                                                   Y Y                  0.00
C                                                                        0.00
DUE FROM PATIENT        0.00        0.00    SERV FAC NPI [redacted]
MEDICAL RECORD NBR[redacted]          COST RPT DAYS      NON COST RPT DAYS
DIAG CODES 01 H40031    02           03           04           05
06           07           08           09                END OF POA IND
ADMITTING DIAGNOSIS              E CODE            HOSPICE TERM ILL IND
IDE                     GAF          0.0000     PRV H40031
PROCEDURE CODES AND DATES 01                 02
03                04                05                06
ESRD HRS 00  ADJ REAS CD CE  REJ CD        NONPAY CD     ATT TAXO _
ATT PHYS        NP[redacted]                                  M    SC 18
OPR PHYS        NP[redacted]                                  M    SC 18
OTH OPR         NPI 0000000000    L                F          M    SC
REN PHYS        NPI 0000000000    L                F          M    SC
REF PHYS        NPI 0000000000    L                F          M    SC
      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

MSP Claim Adjustments

- Claims that reject for MSP (reason codes 34XXX) always post to CWF
  - Cost-avoid
  - These rejected claims must always be adjusted
  - Resubmitting claims rejected for MSP will always result in a duplicate rejection
- Changing a processed Medicare primary claim to MSP also requires a claim adjustment

MSP Claim Adjustments

- Claims in status/location P B9997 are processed
  - Claims are finalized, having met Medicare's claim coding and/or submission requirements
  - Did not reject due to an open MSP record in CWF
- Claims in status/location R B9997 are rejected
  - Reason code range 34XXX (cost-avoided)
  - Claims have met Medicare's claim coding and/or claim submission requirements
  - However, rejected due to open MSP record in CWF
- To make changes to these claims, adjust them

Adjusting Claims That Rejected for MSP

- When claims are rejected for MSP (reason code 34XXX cost-avoids)
  - FISS places charges into "NCOV CHARGES" (noncovered charges) field on claim page 02
- When these rejected claims are adjusted
  - Claim lines must be deleted and added as new covered charge lines
  - Be sure the 0001 Totals line is re-added and calculated appropriately

Avoid a Common Adjustment Error

- When you want to make a change to a processed or cost-avoided claim for an MSP-related reason, you must adjust that claim
  - If you resubmit a new claim, it will reject as a duplicate claim

Using FISS DDE to Adjust an MSP Claim

3. Make claim adjustments
   - Claim change reason code
   - Claim lines
   - Adjustment reason code
   - Primary payer information (CAGC, CARC codes)
   - Remarks
   - Any additional coding (MSP CC, OC, VC codes)

Claim Change Reason Codes (Condition Codes) for MSP Adjustments

Reason Code	Description
D0 (zero)	Changes to service dates
D1	Changes to charges
D2	Changes to revenue/HCPCS/HIPPS rate codes
D3	Second or subsequent interim PPS bill
D4	Changes in ICD-10-CM diagnosis/procedure code • Use for IP acute care hospital, LTCH, IRF, and SNF
D7	Change to Medicare primary, conditional, or cost-avoided claim to make Medicare secondary
D8	Change to MSP claim to make Medicare primary
D9	Any other change to MSP/conditional claim Change to cost-avoided claim to make Medicare primary Any other change (Remarks required)
E0 (zero)	Change in patient status

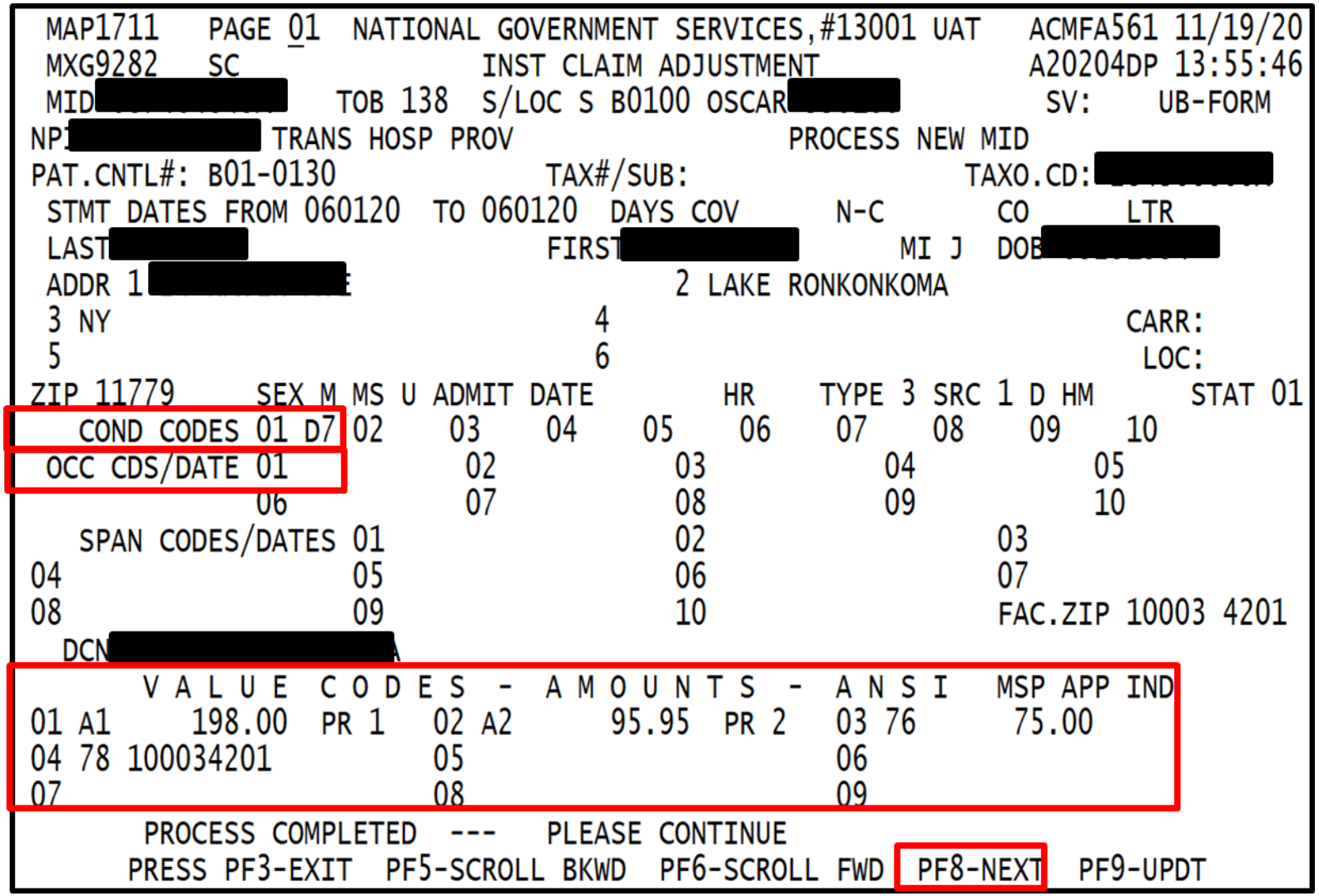
Primary Payer Information

- Claim page 3 (left view-MAP1719) allows providers to enter adjustments from CAS of primary payer's RA (835)
  - CAGCs, CARCs and amounts
- Hit the <F11/PF11> key on claim page 3 to access this option

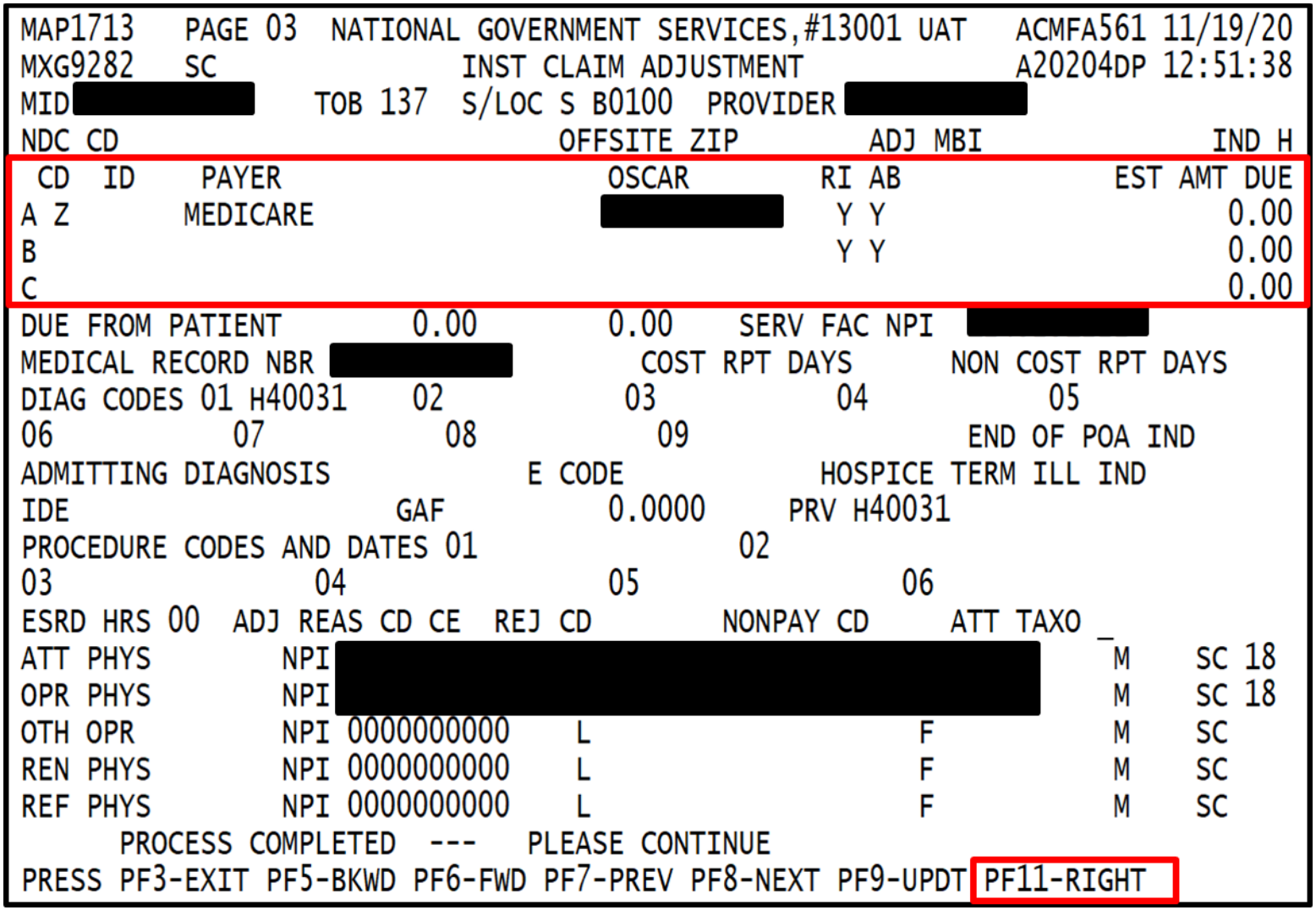
Reporting CAGCs and CARCs

- CAGC(s) from primary payer's RA (835)
  - Identifies general category of payment adjustment
  - Required when primary payer adjusts billed charges
  - Options:
    - **CO** (Contractual Obligations),
    - **CR** (Corrections and Reversals,
    - **OA** (Other Adjustments),
    - **PI** (Payer Initiated Reductions) and
    - **PR** (Patient Responsibility)
- CARC(s) from primary payer's RA (835)
  - Communicates an adjustment
  - Explains why primary payer paid differently from amount billed to them
  - Washington Publishing Company

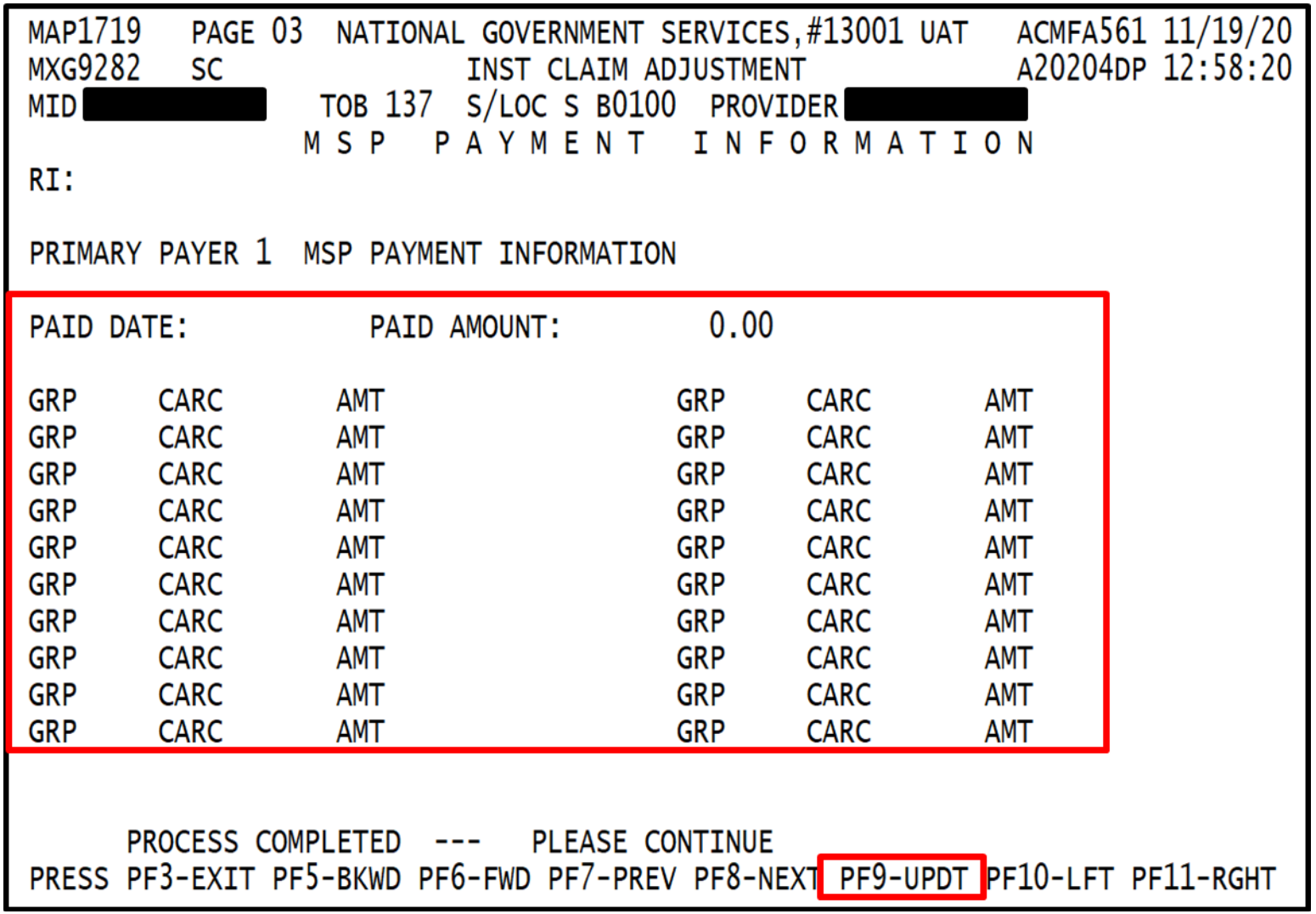
Step 3: Add MSP Coding



Step 3: Add Primary Payer Information



Step 3: Add Primary Payer Information



What You Need to Know About Claim Cancellation

Cancellation - Defined

- Cancels are submitted to **void** a claim record
  - Processed claim reported with incorrect provider/beneficiary information
  - Duplicate Medicare/OIG payment needs to be returned
  - Outpatient claim for services that apply to 3-day payment window policy needs to be withdrawn
- Cancels only apply to claims in S/LOCs
  - P/B9997 (Processed)
  - R/B9997 (Rejected) that have posted to CWF

Using FISS DDE to Cancel a Claim

1. Gather required information
2. Access processed/rejected claim
3. Cancel the claim
   - Claim change reason code
   - Remarks
4. Submit & verify claim cancellation

Step 1: Gather Required Information

- Claim change reason code chart
  - Describes reason why claim is changing
  - Two-digit alpha-numeric code
    - Entered on claim page 1 (condition code)

Reason Code	Description
D5	Cancel to correct MID or Provider ID
D6	Cancel only to repay a duplicate or OIG overpayment (Includes cancellation of an OP bill services required on IP bill)

Step 2: Access the Claim

- Log into FISS DDE
- Select Claims Correction Menu (option 03)
- Select option from Claim and Attachments Correction Menu
  - Based on processed/rejected claim type
    - Inpatient – 50
    - Outpatient – 51
    - SNF – 52
    - Home Health – 53
    - Hospice – 55

Step 2: Access the Claim

- Enter MBI and DOS
  - List of processed claims will be displayed
  - To view list of rejected claims that can be cancelled, overwrite ‘P’ in status field with ‘R’
- Select claim to be adjusted by placing ‘U’ in SEL field
  - Claim opens at page 1
  - TOB automatically changes to XX8
  - System pulls in DCN from claim to be canceled

Step 3: Cancel Claim

- On claim page 1, enter claim change reason code in CC field
  - D5 or D6 only
- For any situation where cancellation requires some explanation, enter Remarks on claim page 4
  - Remarks otherwise not mandatory for cancellations

Step 4: Submit & Verify Claim Cancel

- Review changes to ensure accuracy
- Hit <F9/PF9> to cancel claim
- Verify that claim was stored correctly by going into Inquiries submenu (Option 01) and choosing Claims Summary option (Menu 12)
  - Available next day after cancelling claim (<F9/PF9>)
  - Key patient's MBI and from/through dates of cancelled claim
  - Cancelled claim should appear in 'S' Location
  - TOB = XX8

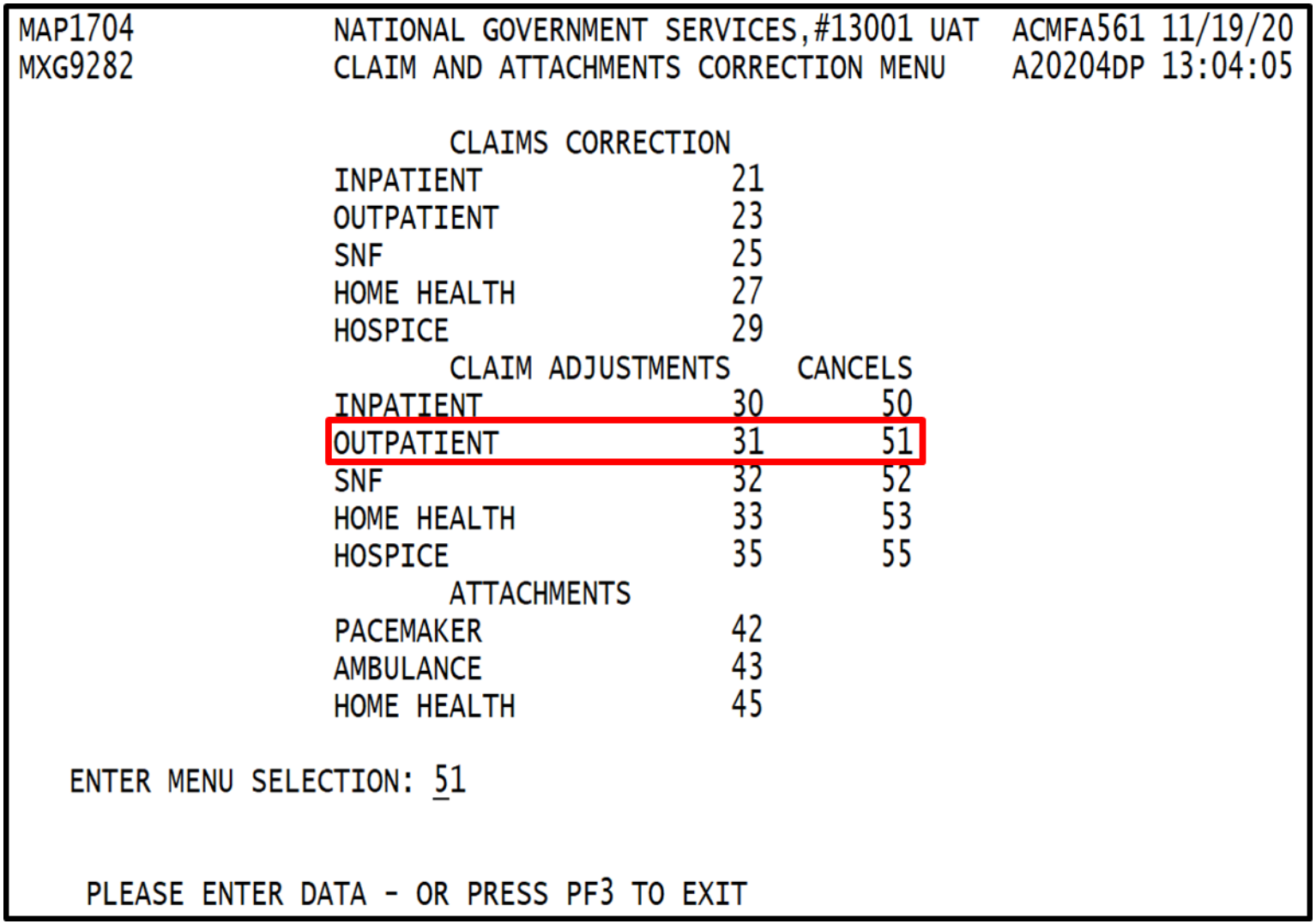
FISS DDE Claim Cancel Demonstration: Incorrect Beneficiary Information

- Outpatient claim submitted with incorrect MBI
  - Data entry error posted reimbursement to wrong patient account
- Claim must be cancelled

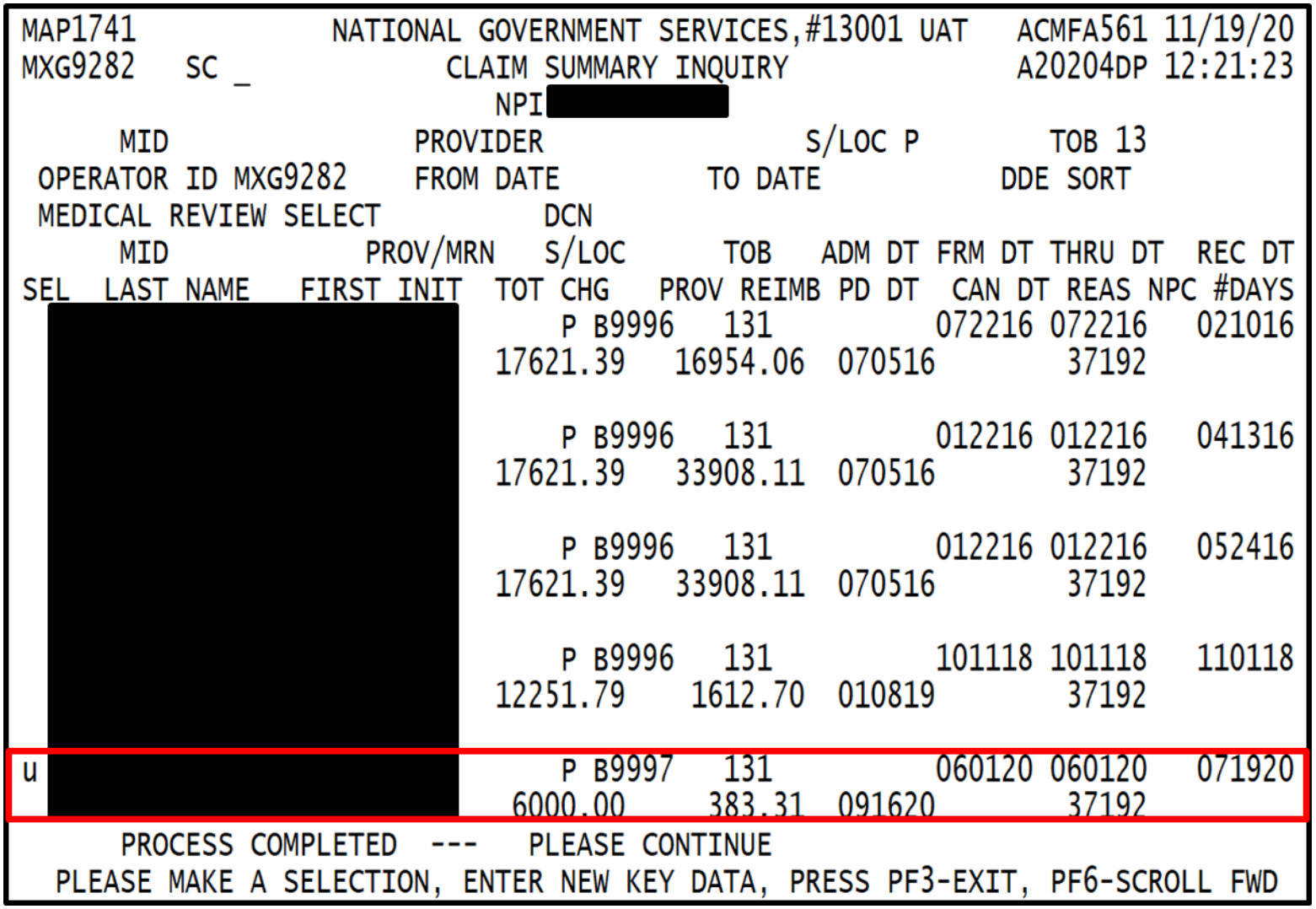
Step 1: Gather Required Information

- Reason for cancel
  - Incorrect MBI
- Appropriate claim change reason code
  - D5

Step 2: Access the Claim



Step 2: Access the Claim



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MXG9282   SC _              CLAIM SUMMARY INQUIRY             A20204DP 12:21:23
                              NPI [redacted]
      MID                PROVIDER                S/LOC P        TOB 13
 OPERATOR ID MXG9282     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
 [redacted]                      P B9996   131          072216 072216   021016
                          17621.39   16954.06  070516        37192

                                 P B9996   131          012216 012216   041316
                          17621.39   33908.11  070516        37192

                                 P B9996   131          012216 012216   052416
                          17621.39   33908.11  070516        37192

                                 P B9996   131          101118 101118   110118
                          12251.79    1612.70  010819        37192

u [redacted]                     P B9997   131          060120 060120   071920
                           6000.00     383.31  091620        37192

      PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
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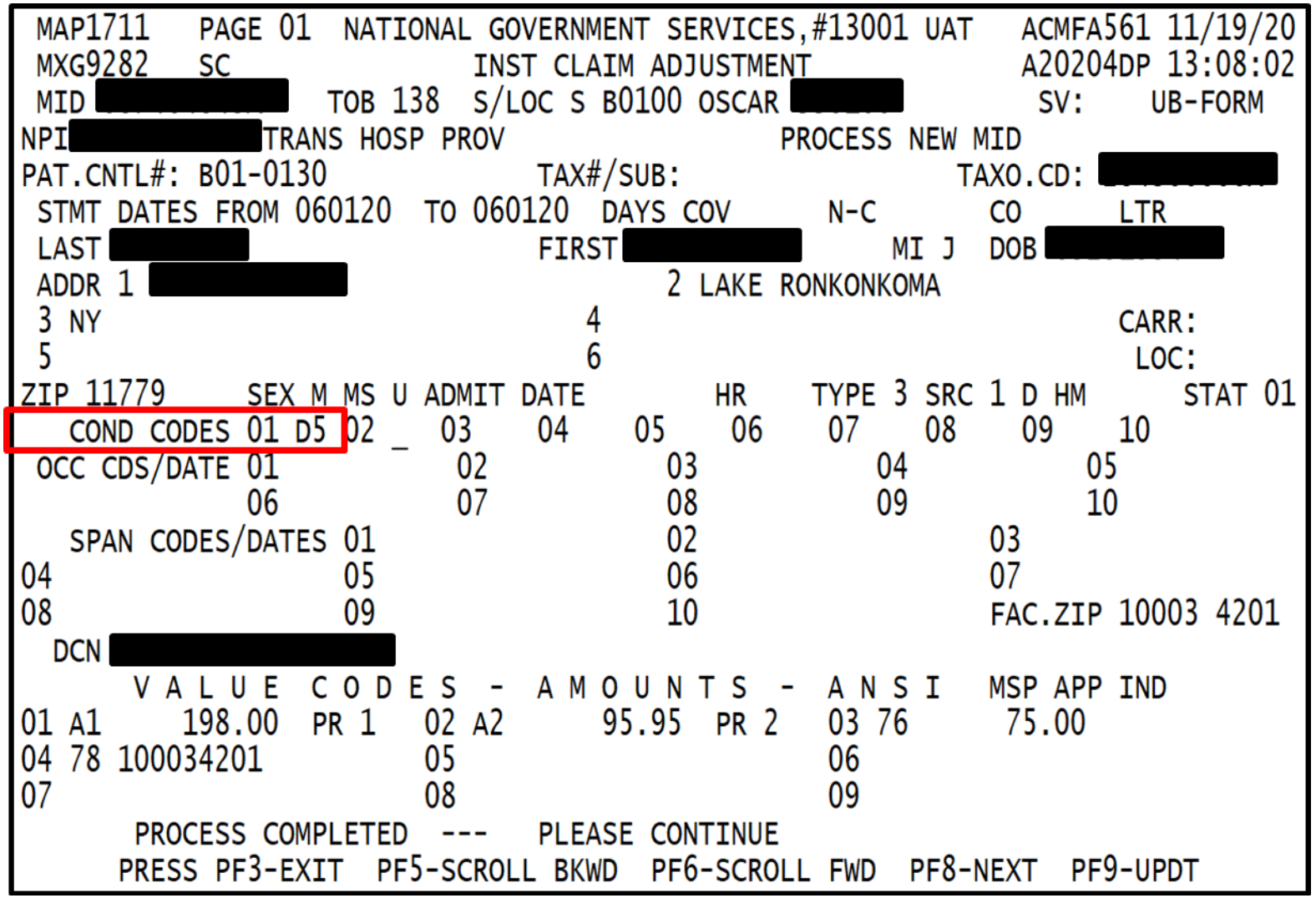
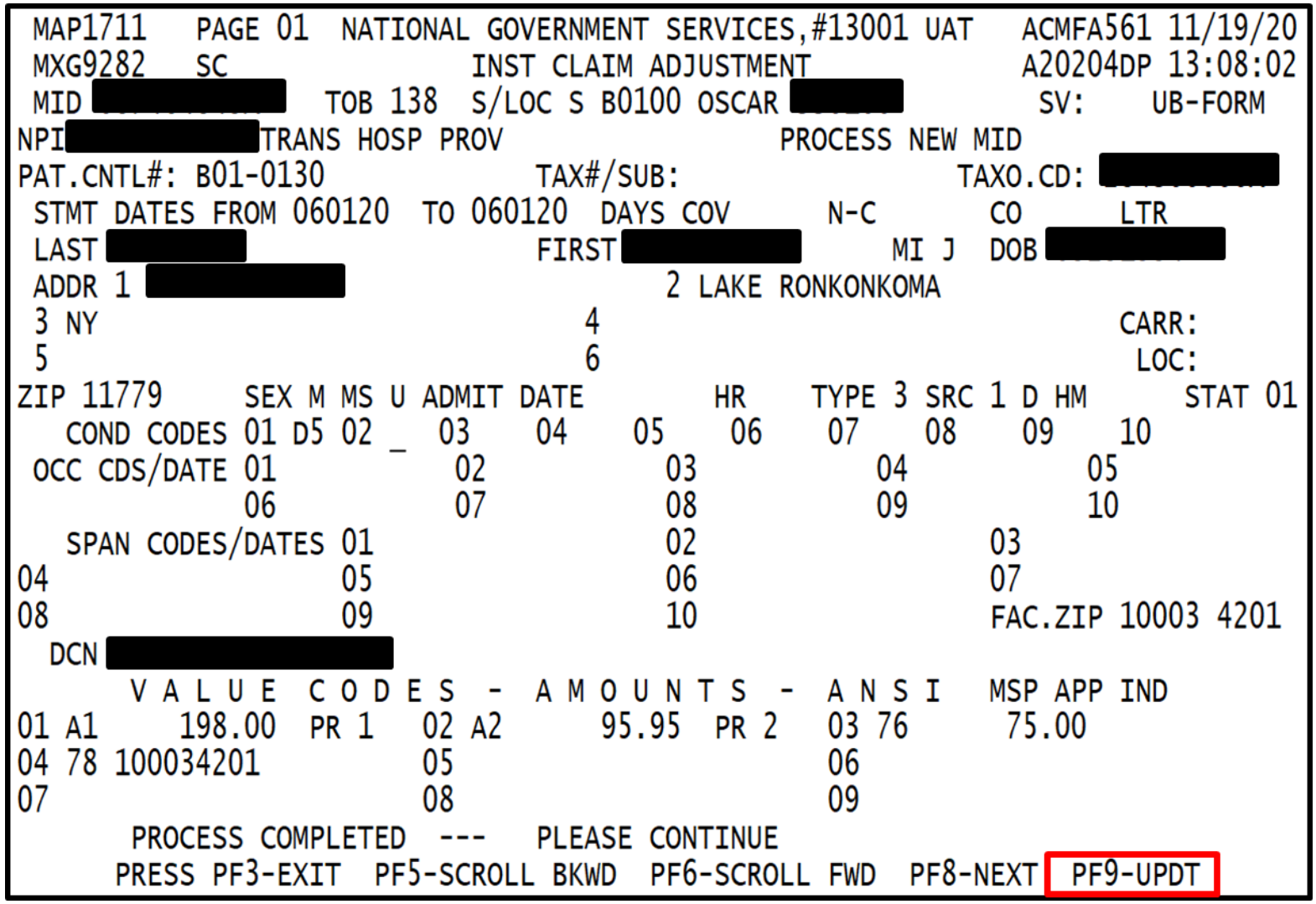
Step 3: Add Claim Change Reason Code



Step 4: Submit Claim Cancellation



Claim Adjustments and Cancels: Special Billing Instructions

How Do Claim Adjustments Relate to Timely Filing Guidelines?

- Adjustments follow CMS regulations for timely filing of claims
  - Adjustments must be submitted within one year of date of service to be considered timely
  - Inpatient claims will be considered timely if submitted within one year of claim “through” date

Timely Filing Exceptions

- Change Request 7270 exceptions to one year calendar claim filing time limit
  - Administrative error
  - Retroactive Medicare entitlement
  - Retroactive Medicare entitlement involving state Medicaid agencies
  - Retroactive disenrollment from a MA plan

Adjusting Claims to Request a Bypass to Timely Filing Guidelines

- If claim meets one of valid exceptions for timely filing, submit a claim adjustment
  - D9 claim change reason code
  - OT adjustment reason code
  - Add remarks on claim page 4 in FISS DDE
    - "Please bypass timely filing because..."
      - Add a clear and concise reason

Timeliness of MSP Adjustments

- If original claim processed as MSP claim and primary payer later takes their payment back from provider
  - You may adjust that MSP claim within one year of its process date
- If original claim processed as Medicare primary claim and primary payer later makes payment to provider
  - You may adjust that primary claim beyond one-year timely filing period since Medicare is being reimbursed
  - If liability is primary payer, refer to instructions provided in CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2. letter E

Adjusting LCD or NCD Partially Denied Claims

- Applies to claims with a line item denial reason code of 55A00, 55A01, 52NCD, 53NCD, or **54NCD and the 59xxx series.**
- Make appropriate corrections to diagnosis code
  - Use claim change reason code D9 (add remarks)
  - Adjustment reason code LN
  - Delete and rekey denied line(s) back to covered

Adjusting Other Partially Denied Claims

- Adjustments can be made on any partially denied claim if you are not disputing line item denial
  - For example, you may adjust to add additional services and charges
- Submit adjustment
  - D9 claim change reason code
  - OT adjustment reason code
  - Remarks stating, “Not disputing medically denied line(s), adjusting to…”
  - Provide a clear and concise explanation

Adjusting Recovery Auditor Claims

- You can make changes to RA processed adjustments on FISS DDE as long as you do not change any information related to RA decision
- Submit adjustment
  - Claim change reason code D9
  - Adjustment reason code OT
  - Remarks: “Not disputing RA decision, adjusting to…”
    - Add a clear and concise explanation

Higher-Weighted DRG Adjustments

- Adjusting processed IP hospital claims may result in higher weighted DRG
- Required to be submitted within 60 days
  - Remittance advice date
- Adjustments reviewed by QIO on postpayment basis

Preadmission Services Window

- Inpatient and outpatient claims overlap because of preadmission services window policy
  - Within 72 hours (PPS) or 24 hours (non-PPS)
- Must cancel outpatient claim if all services are related to inpatient admission
  - Claim Change Reason Code D6
- Then adjust inpatient claim
  - Add all applicable diagnostic services on inpatient claim
  - Add non diagnostic services if they are related to inpatient admission

Condition Code 51

- If non diagnostic services within preadmission services window are not related to inpatient admission, adjust outpatient claim to add CC 51
- CR 7142 “Clarification of Payment Window for Outpatient Services Treated as Inpatient Services” issued 10/29/2010

References and Resources

References & Resources

- NGS website
  - Part A > Education > Manuals
    - FISS DDE Provider Online Guide
    - “Reminder on Deleting Revenue Code Lines in the Fiscal Intermediary Standard System Direct Data Entry System”

Resources and References

- NGS website
  - Part A > Resources > Claims & Appeals > Medicare Secondary Payer
    - Prevent an MSP Rejection on a Medicare Primary Claim
    - Collect and Report Retirement Dates on Medicare Claims
    - Prepare and Submit an MSP Claim
    - Prepare and Submit an MSP Conditional Claim
    - Correct or Adjust a Claim Due to an MSP-Related Issue

References & Resources

- CR6426, “Instructions on utilizing 837 Institutional CAS segments for Medicare Secondary Payer (MSP) Part A Claims”
- CR7142 “Clarification of Payment Window for Outpatient Services Treated as Inpatient Services”

Resources & References

- CR7355, "Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims"
- CR8486, "Instructions on Using the Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A CMS-1450 Paper Claims, Direct Data Entry (DDE), and 837 Institutional Claims Transactions"

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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