Medlearn Matters
Information for Medicare Providers

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MMA- Section 937 - Correction of Minor Errors and Omissions Without Appeals

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

Understand the Medicare rules that enable you to correct minor errors and omissions on Medicare claims without having to go through the appeals process. This article will provide information needed to make such minor corrections to Medicare claims within existing procedures.

Background

Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-73, requires the Secretary of the Department of Health and Human Services to establish a process for physicians, providers, and suppliers to correct minor errors and omissions in claims without pursuing the formal appeals process. The Centers for Medicare & Medicaid Services (CMS) currently provides the following ways to make such corrections:

1. Correcting Incomplete or Invalid Claims Submissions

Medicare instructions currently provide an opportunity for physicians, suppliers, and providers to correct errors or omissions in a submitted claim without the need to initiate a formal appeal, such as a review or, reconsideration. These processes are outlined in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 1 - General Billing Requirements, section 80.3.2 - Handling Incomplete or Invalid Claims* and *Section 70.2.3.1 - Incomplete or Invalid Submissions*.

The instructions provide the rationale for determining whether a claim (Forms CMS-1450, CMS-1500 or their electronic equivalent) is considered complete for processing purposes and outlines the actions to be taken by contractors upon receipt of incomplete or invalid claim submissions.

Basically, the instructions identify incomplete claims as ones submitted with required information missing, such as the provider's name. Invalid submissions also are claims that contain complete and required information, but the information is illogical or incorrect (e.g., incorrect HIC# or invalid procedure code) or the information does not conform to required claim formats.

The following definitions may be applied to determine whether data on submitted claims are incomplete or invalid:

- Required – Any data element that is needed in order to process the submission, such as provider name.
- Not Required – Any data element that is optional or is not needed to process the submission, such as the patient's marital status.
- Conditional – Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Based on these instructions, if a claim is submitted with missing or incorrect information for certain specified items, it is considered to be unprocessable and is to be "returned" to the provider. Returning a claim as unprocessable does not mean that every claim is physically returned to the provider. The terms "return as unprocessable" or "return to provider" refer to the many processes utilized for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted.

Different contractors use various techniques for returning claims as unprocessable. Following are just two examples:

- If incomplete or invalid information is detected at the front-end of claims processing, the claim may be returned to the provider identifying the error(s) and explaining how to correct the errors prior to resubmission.
- If incomplete or invalid information is detected at the front-end of the claims processing system, the claim may be suspended and developed; requested corrections and/or medical documentation must be submitted within a 45-day period. After the requested information is received, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the remittance advice.

Under these instructions, carriers and fiscal intermediaries (FIs) typically either suspend claims with defective data for development and correction by the provider or send the claim back to the provider, noting the missing or incorrect items, for correction and resubmission. Claims submissions that are returned to the provider are not considered claims under Medicare regulations. Therefore, neither of these processes allows for the initiation of an appeal.

For more details on these sections, you may view *Chapter 1, Sections 70.2.3.1* and *80.3.2*, of the *Medicare Claims Processing Manual, Pub. 100-04*, at:

http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Once at that site, scroll down to Chapter 1 and click on the file type you wish to download.

2. Correcting Mistakes in Previously-Processed Claims

Another process a provider can use is the Adjustment Request Process. Adjustment requests are the most common mechanism for FIs to change a previously accepted bill. The Adjustment Payment Process is outlined in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 3 - Inpatient Hospital Billing, section 50, Adjustment Bills*. Adjustments are required when bills have been accepted and posted in error to a particular record.

You may also view this section of the manual to obtain further details on adjustments by going to:

http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Once at that page, scroll down to Chapter 3 and click on the type of file you wish to download.

3. Reopening Claims

A third process that providers can use is the Reopening Process. Section 1869(b) (1) (G) of the Act provides for the reopening and revision of any initial determination according to guidelines prescribed by the Secretary. The *Medicare Claims Processing Manual, Pub. 100-4, Chapter 29 - Appeals of Claims Decisions, section 60.27 - Reopening and Revision of Claims Determinations and Decisions*, distinguishes the reopening process from the appeals process.

The purpose for a reopening should be to change the determinations or decisions that result in either overpayments or underpayments. Reopenings have been misconstrued as a level of the appeals process. A reopening is not an appeal right; it is a discretionary action as defined under 42 CFR 405.841.

Requests for adjustments to claims resulting from clerical errors must be handled through the reopening process. The request must be made within one year from the date of the notice of the initial determination. A provider has a four-year timeframe to initiate a reopening after the date of the initial determination if good cause exists.

4. Correcting HIPAA Compliance Issues

The fourth process relates to CMS's existing process for evaluating a claim's HIPAA compliance. This process can be found in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 24 - EDI Support Requirements, sections 30.6 - Translators; 70.1 - FI Requirements*; and *70.2 - Carrier/DMERC Requirements*.

Currently, Medicare contractor translators validate the syntax compliance of the X12N 837 standard. The entire file will be rejected when the file is syntactically incorrect. The contractor will send to the provider the X12N 997 Functional Acknowledgment to report the syntax errors. If the file is syntactically correct, HIPAA-implementation guide-compliance validation of the X12N 837 is performed. Compliance validation edits check for required loops and segments, appropriate segments within a loop, valid calendar dates, qualifiers, and so on. Individual claims are rejected to the provider when they contain errors. The errors are then reported on contractor specific error reports.

To view the manual sections on reopening information or for the HIPAA information, use the same Web address as provided above and scroll to Chapters 29 and 24, respectively. Once at each chapter, select the version of the file you wish to review.

Additional Information

If you encounter problems or have any questions, please contact your carrier or FI on their toll-free number. If you do not have that number, you may find it at:

http://www.cms.hhs.gov/medlearn/tollnums.asp