PALMETTO GBA®

A CELERIAN GROUP COMPANY

A CMS Medicare Administrative Contractor

Direct Data Entry (DDE) User's Guide

Section 5: Claims Correction

Main Menu Option 03

September 2018

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ACRONYMS

Acronym	Description
A	
ACS	Automated Correspondence System
ADR	Additional Development Request
ADJ	Adjustment
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center
ANSI	American National Standards Institute
B	
C	
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMG	Case-mix Group
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CO	Contractual Obligation
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CWF	Common Working File
D	
DCN	Document Control Number
DDE	Direct Data Entry
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSH	Disproportionate Share Hospital
E	
EDI	Electronic Data Interchange
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
F	
FDA	Food and Drug Administration
FI	Fiscal Intermediary

Acronym	Description
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Centers
G	
H	
HCPC	Healthcare Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
HIPPS	Health Insurance Prospective Payment System (the coding system for home health claims)
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRR	Hospital Readmission Reduction
HSA	Health Service Area
HSP	Hospital Specific Payment
HSR	Hospital Specific Rate
I	
ICD	Internal Classification of Diseases
ICN	Internal Control Number
IDE	Investigational Device Exemption
IEQ	Initial Enrollment Questionnaire
IME	Indirect Medical Education
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
J	
K	
L	
LGHP	Large Group Health Plan
LOS	Length of Stay
LTR	Lifetime Reserve days
M	
MA	Medicare Advantage Plan
MAC	Medicare Administrative Contractor
MCE	Medicare Code Editor
MID	Beneficiary's Medicare Number (formerly Health Insurance Claim Number[HICN])
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N	
NDC	National Drug Code
NIF	Not in File
NPI	National Provider Identifier

Acronym	Description
O	
OCE	Outpatient Code Editor
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
ORF	Outpatient Rehabilitation Facility
OSC	Occurrence Span Code
OTAF	Obligated To Accept in Full
OT	Occupational Therapy
P	
PC	Professional Component
PHS	Public Health Service
PPS	Prospective Payment System
PR	Patient Responsibility
PRO	Peer Review Organization
PS&R	Provider Statistical and Reimbursement Report
PT	Physical Therapy
Q	
R	
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return To Provider
S	
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SLP	Speech Language Pathology
SMSA	Standard Metropolitan Statistical Area
T	
TC	Technical Component
TOB	Type of Bill
U	
UB	Uniform Billing
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
URC	Utilization Review Committee
V	
W	
X	
X-Ref	Cross-reference
Y	
Y2K	Year 2000
Z	

DIRECT DATA ENTRY (DDE) USER'S GUIDE BREAKDOWN

Refer to the following sections of the DDE User Guide for detailed information about using the DDE screens.

Section	Section Title	Descriptive Language
1	Introduction & Connectivity	This section introduces you to the Direct Data Entry (DDE) system, and provides a list of the most common acronyms as well navigational tips to include function keys, shortcuts, and common claim status and locations. This section also provides screen illustrations with instructions for signing on, the main menu display, signing off, and changing passwords.
2	Checking Beneficiary Eligibility	This section explains how to access beneficiary eligibility information via the Common Working File (CWF) screens, Health Insurance Query Access (HIQA) and Health Insurance Query for HHAs (HIQH), to verify and ensure correct information is submitted on your Medicare claim. Screen examples and field descriptors are also provided.
3	Inquiries (Main Menu Option 01)	This section provides screen illustrations and information about the inquiry options available in DDE, such as viewing inquiry screens to check the validity of diagnosis codes, revenue codes, and HCPCS codes, checking beneficiary/patient eligibility, check the status of claims, view Additional Development Requests (ADRs) letters, Medicare check history, and home health payment totals.
4	Claims & Attachments (Main Menu Option 02)	This section includes instructions, screen illustrations, and field descriptions on how to enter UB-04 claim information, including home health requests for anticipated payment (RAPs), hospice notice of elections (NOEs), and roster bill data entry.
5	Claims Correction (Main Menu Option 03)	This section provides instructions, screen illustrations, and field descriptions on how to correct claims that are in the Return to Provider (RTP) file, adjust or cancel finalized claims.
6	Online Reports (Main Menu Option 04)	This section provides information on certain provider-specific reports that are available through the DDE system.

This publication was current at the time it was published. Medicare policy may change so links to the source documents have been provided within the document for your reference.

This publication was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Any changes or new information superseding the information in this guide are provided in the Medicare Part A and Home Health and Hospice (HHH) Bulletins/Advisories with publication dates after September 2018. Medicare Part A and HHH Bulletins/Advisories are available at www.PalmettoGBA.com/medicare.

SECTION 5 – CLAIMS CORRECTION

The Claim and Attachments Correction Menu displays (Figure 1) when '**03**' is chosen from the Main Menu. The detailed explanations for the claim page screens are provided in **Section 4: Claims & Attachments**.

Claim and Attachments Correction Menu Screen (MAP1704)

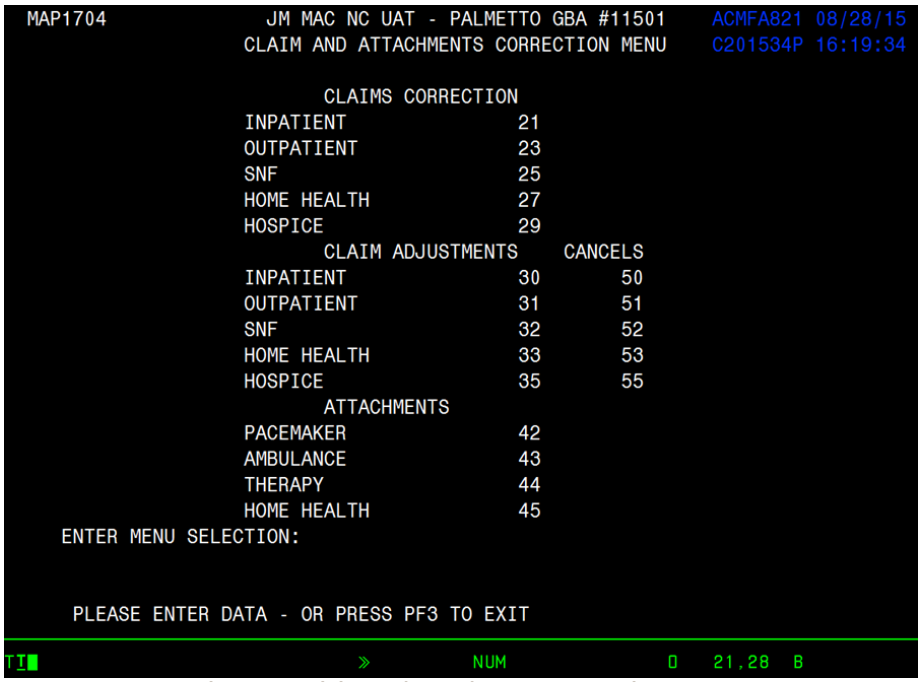

Figure 1 – Claim and Attachments Correction Menu

Claim correction allows you to:

- Correct Return To Provider (RTP) claims
- Suppress RTP claims that you do not wish to correct
- Adjust claims
- Cancel claims

Note: The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, the user will need to change the provider number to inquire or input information. **[TAB]** to the PROVIDER field and type in the correct provider number.

5.A. Online Claims Correction

If a claim receives an edit (FISS reason code), a Return to Provider (RTP) is issued. An RTP is generated after the transmission of the claim. The claim is returned for correction. Until the claim is corrected via DDE or hardcopy, it will not process. When an RTP is received, the claim is given a Status/Location code beginning with the letter 'T' and routed to the Claims Summary Inquiry screen. Claims requiring correction are located on the Claim Summary screen the day after claim entry. It is not possible to correct a claim until it appears on the summary screen. Providers are permitted to correct **only** those claims appearing on the summary screen with status 'T'. Claims that have been given 'T' status have not yet been processed for payment consideration, so it is important to review your claims daily and correct them in order to avoid delays in payment.

5.A.1. Claim Summary Inquiry

Once an option is chosen from the Claim and Attachments Correction Menu, the Claim Summary Inquiry screen (Figure 2) will display.

Claim Summary Inquiry Screen (MAP1741) – Field descriptions are provided in the table following Figure 2.

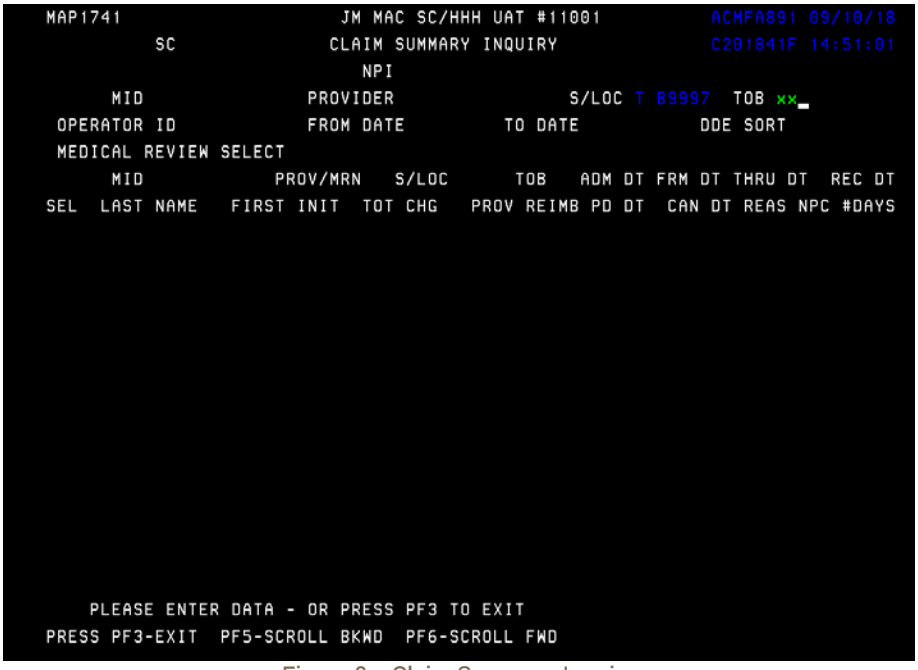

Figure 2 – Claim Summary Inquiry

Certain information is already completed, including the provider number, the status/location where RTP claims are stored (T B9997), and the first two digits of the type of bill. To narrow the selection, enter any or all of the information in the following table.

Field Name	Description
DDE SORT	Allows multiple sorting of displayed information. Valid values include: ' ' = TOB/DCN (Current default sorting process, S/LOC, Name) M = Medical Record number sort (Ascending order, Beneficiary's Medicare Number) N = Name sort (Alpha by last name, first initial, Receipt Date, MR#, Beneficiary's Medicare Number) H = Beneficiary's Medicare Number sort (Ascending order, Receipt Date, MR#) R = Reason Code sort (Ascending Order, Receipt Date, MR#, Beneficiary's Medicare Number) D = Receipt Date sort (Oldest Date displaying first, MR#, Beneficiary's Medicare Number
MEDICAL REVIEW SELECT	Used to narrow the claim selection for inquiry. This will provide the ability to view pending or returned claims by medical review category. Valid values include: ' ' = Selects all claims 1 = Selects all claims 2 = Selects all claims excluding Medical Review 3 = Selects Medical Review only

To see a list of the claims that require correction, press **[ENTER]**. The selection screen will then display all claims that have been returned for correction (status/location T). To narrow the scope

of the claims viewed, enter one of the following selection criteria, type of bill, from date, to date, and Medicare number. If the claim you are looking for does not display on the screen, do the following:

- Verify the Medicare Number that you typed.
- Verify the 'from' and 'through' dates.
- Verify that the type of bill (TOB) is the same as the TOB on the claim you originally submitted. If not, **[TAB]** to the TOB field and enter the first two digits of the TOB for the claim you are trying to retrieve.
- If you still cannot find the claim, back out of Claims Correction (press **[F3]**) all the way to the Main Menu. Choose Inquiry (option 01), then Claims (option 12), and select the claim. Check the status/location (S/LOC). **Only claims in status location T B9997 can be corrected.** Status locations that cannot be corrected include:
  - **P B9997** – This claim has paid. An adjustment is required in order to change a paid claim.
  - **P 09998** –This claim was paid but due to its age, it has been moved to off-line history. Timeliness of filing will not allow you adjust this claim.
  - **P B9996** – This claim is waiting to be released from the 14-day payment floor (not showing on the RA). No correction allowed.
  - **R B9997** – This claim was rejected. Submit a new claim or an adjustment.
  - **D B9997** – This claim was denied and may not be corrected or adjusted.

5.A.2. Claims Correction Processing Tips

- The Revenue Code screen has multiple sub-screens. If you have more Revenue Codes than can fit on one screen, press **[F6]** to go the next sub-screen. Press **[F5]** to go back to the previous screen.
- You can also get from page to page by entering the page number in the top left corner of the screen (Page).
- Reason codes will display at the bottom left of the screen to explain why the claim was returned. Up to 10 reason codes can appear on a claim.
- Pressing **[F1]** will access the reason code file and automatically display the narrative for the first reason code listed on the left corner of the claim screen. Subsequent reason codes can be entered manually to view the narrative.
- Press **[F3]** to return to the claim.
- The reason code file can be accessed from any claim screen by pressing **[F1]**.
- The inquiry screen can also be accessed by typing the option number in the 'SC' field in the upper left hand corner of the screen. For example, enter '10' for beneficiary/patient information screen in the 'SC' field and press **[Enter]**. Press **[F3]** to return to the claim.

5.A.3. Correcting Revenue Code Lines

To delete an entire Revenue Code line:

- **[TAB]** to the line and type zeros over the top of the Revenue Code to be deleted or type '**D**' in the first position.
- Press **[HOME]** to go to the Page Number field. Press **[ENTER]**. The line will be deleted.
- Next, add up the individual line items and correct the total charge amount on Revenue Code line (0001).

To add a Revenue Code line:

- Tab to the line below the total line (0001 Revenue Code).
- Type the new Revenue Code information.

- Press **[HOME]** to go to the Page Number field. Press **[ENTER]**. The system will resort the Revenue Codes into numerical order.
- Perform the 'delete' function on Revenue Code line (0001) and add it back to the bottom to correct the total charges and units.

Changing total and non-covered charge amounts:

- **[TAB]** to get to the beginning of the total charge field on a line item.
- Press **[END]** to delete the old dollar amount. It is very important ***not*** to use the spacebar to delete field information. Always use **[END]** when clearing a field.
- Type the new dollar amount without a decimal point. Example: for $23.50 type '2350'.
- Press **[ENTER]**. The system will align the numbers and insert the decimal point.
- Correct the totals line, if necessary.
- To exit without transmitting any corrections, press **[F3]** to return to the selection screen. Any changes made to the screen will not be updated.
- Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom left of the screen. Continue the correction process until the system takes you back to the claim correction summary.
- The on-line system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check (S B2500, unless otherwise set in the System Control file). The claim will continue forward when nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will appear at the bottom of the screen: PROCESS COMPLETED – ENTER NEXT DATA.

5.A.4. RTP Selection Process

From the Claim Summary Screen (Figure 2), select the claim to be corrected by tabbing to the 'SEL' field for the first line of the claim to be corrected. Type a '**U**' or '**S**' and press **[ENTER]**. The beneficiary/patient's original UB-04 claim will display. (This will be MAP1711, the first page of the claim).

Type Information:

- Use the Function keys listed at the bottom of the screen to move through the claim (i.e., **[F8]** to go to the next screen, **[F7]** to back up a screen).
- The Revenue Code screen has multiple sub-screens. If you have more revenue codes than can fit on one screen, press **[F6]** to go the next sub-screen. Press **[F5]** to go back to the first screen.
- You can also get from page to page by entering the page number in the top left of the screen.

Reason Codes will appear at the bottom of the screen (Figure 3) to explain why the claim was returned. Up to ten reason codes can appear on a claim.

INST Claim Update Screen – Claim Page 1 (MAP1711)

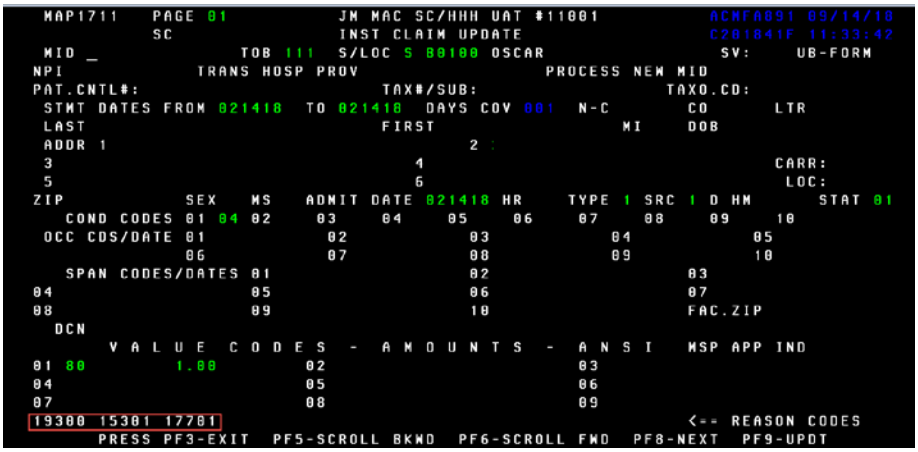

Figure 3 – UB-04 Claim Entry, Page 1

Press **[F1]** to access the Reason Code file (Figure 4). The system automatically pulls up the first reason code with its message. The message will identify the fields that are in error and will suggest corrective action. Press **[F3]** to return to the claim, or type in an additional reason code and press **[ENTER]**.

Reason Codes Inquiry Screen (MAP1881). Field descriptions are in the table following Figure 4.

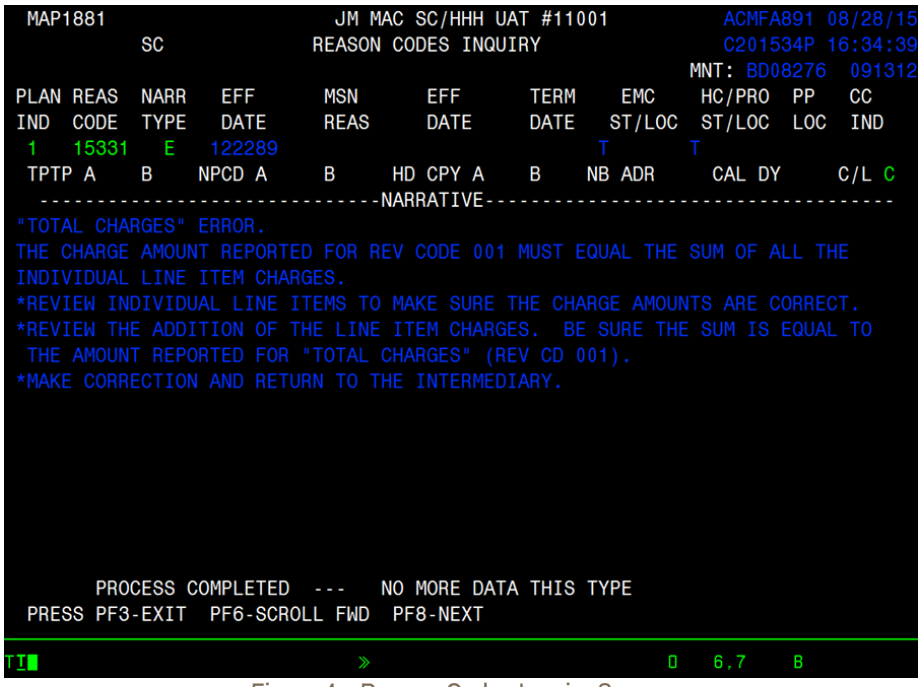

Figure 4 – Reason Codes Inquiry Screen

Field Name	Description
MNT	Identifies the last date the reason code was updated.
PLAN IND	Plan Indicator. All FISS shared maintenance customers will be '1'; the value for FISS shared processing customers will be determined at a later date.
REAS CODE	Identifies a specific condition detected during the processing of a record.
NARR TYPE	The 'type' of reason code narrative provided. This field defaults to 'E' for external message.

Field Name	Description
EFF DATE	Identifies the effective date for the reason code or condition.
MSN REAS	The Medicare Summary Notice reason code is used when MSN's requiring BDL messages are produced. The reason code on the claim will be tied to a specific MSN reason code on the reason code file that will point to a specific MSN message on the ACS/MSN file.
EFF DATE	Effective date for the MSN reason code.
TERM DATE	Termination date for the MSN reason code.
EMC ST/LOC	Identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. If it is the same for both hard copy and EMC claims, the data will only appear in the hard copy category and the system will default to the hard copy claims for action on EMC claims.
HC/PRO ST/LOC	Hardcopy/Peer Review Organization status and location code for hard copy (paper) and peer review organization claims. This is the path DDE will follow.
PP LOC	This field identifies the five-position alphanumeric post pay location of 'B75XX'.
CC IND	The clean claim indicator instructs the system whether to pay interest or not if applicable.
TPTP A	Tape-to-tape Flag indicator for Part A, which controls the flow of the claim to CWF, to the provider via the remittance advice, to the PS&R system and for counting the claim for workload purposes.
B	Tape-to-tape Flag indicator for Part B.
NPCD A	The Non-pay code for Medicare Part A, which identifies the reason for Medicare's decision not to make payment.
B	The Non-pay code for Medicare Part B, which identifies the reason for Medicare's decision not to make payment.
HD CPY A	This field instructs the system to generate a specific hardcopy document during the claim process on a Medicare Part A claim.
B	This field instructs the system to generate a hardcopy document during the claim process on a Medicare Part B claim.
NB ADR	This field identifies the number of times an Additional Documentation Request (ADR) form is to be generated. Identified by a '1' or a '2'.
CAL DY	This field identifies the number of calendar days a claim is to orbit after the generation of an ADR.
C/L	This field identifies if the reason code has been has been depicted as applying to the Claim or Line.
NARRATIVE	This field displays the description for the reason code.

Type Information:

- The reason codes may be accessed from any claim screen.
- The Inquiry screen can be accessed by typing the option number in the 'SC' field in the upper left hand corner of the screen. For example, type '15' in the 'SC' field to access the DX/PROC Codes screen. Press **[F3]** to return to the claim.

Press **[F3]** to return to the selection screen. Any changes made to the screens will not be updated. Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom of the screen. Continue the correction process until the system takes you back to the Claim Correction Summary.

Note: The online system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check. The claim will continue forward when the nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the **corrected** claim has been successfully updated, the claim will disappear from the screen. The following message will display at the bottom of the screen PROCESS COMPLETED - ENTER NEXT DATA.

5.A.5. Suppressing RTP Claims

A feature exists within DDE that allows a claim to be suppressed because RTP claims do not purge from the FISS for 60 days or longer. This is a helpful function for RTP claims filling up unnecessary space under the Claim Correction Menu option. This action will hide from view the claims in the Claim Correction Menu option; however, all claims will continue to display through the Inquiry Menu option until they purge from the system.

Type a '**Y**' in the SV field located in the upper right hand corner of page 1 and then press **[F9]**. The system will return you to the Claim Summary Inquiry screen. ***NOTE: This action CANNOT be reversed, which means the claim cannot be reactivated. Be sure that you want to perform this function before doing so.***

5.A.6. Claims Sort Option

DDE claims are normally displayed in type of bill order depending on the two-digit number selected from the Claim and Attachments Correction Menu. The claim sort option allows a provider to choose the sort order. To sort the DDE claims, type one of the following values in the DDE SORT field and press **[ENTER]**:

M = Displays claims in Medical Record Number order. The dual-purpose field labeled PROV/MRN will display the provider number unless you choose this sort option.
N = Displays claims in the beneficiary/patient last name order.
H = Displays claims in Beneficiary Medicare number order.
R = Displays claims in Reason Code order.
D = Displays claims in Receipt Date order.

5.B. Claims and Attachments Corrections

5.B.1. Adjustments

When claims are keyed and submitted through DDE or the electronic claims filing system for payment consideration, the user can sometimes make entry mistakes that are not errors to the DDE/FISS system. As a result, the claim is processed through the system to a final disposition and payment. To change this situation, the on-line claim adjustment option can be used to submit adjustments for previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter 'P' and is recorded on the claim status inquiry screen.

A claim cannot be adjusted unless it has been finalized and is reflected on the remittance advice. In addition, a home health Request for Anticipated Payment (RAP), TOB 322, cannot be adjusted.

Providers must be very careful when creating adjustments. If you go into the adjustment system and update a claim without making the right corrections, the adjustment will still be created and process through the system. Errors could cause payment to be taken back unnecessarily.

No adjustments can be made on the following claims:

- **R** = Rejected claims unless the claim posted to CWF.
  - View the TPE-TO-TPE (see Figure 5) field to determine if the claim posted to CWF. If there is an 'X' in the TPE-TO-TPE field, the claim did not post to CWF and cannot be adjusted. If the TPE-TO-TPE field is blank or has a value other than 'X' and adjustment can be performed.
- **T** = RTP claims
- **D** = Denied claims (view the reason code narrative to determine if the claim was medically denied or denied for a non-medical reason)
- Type of Bill XXP (PRO adjustment) or XXI (Medicare contractor adjustment)

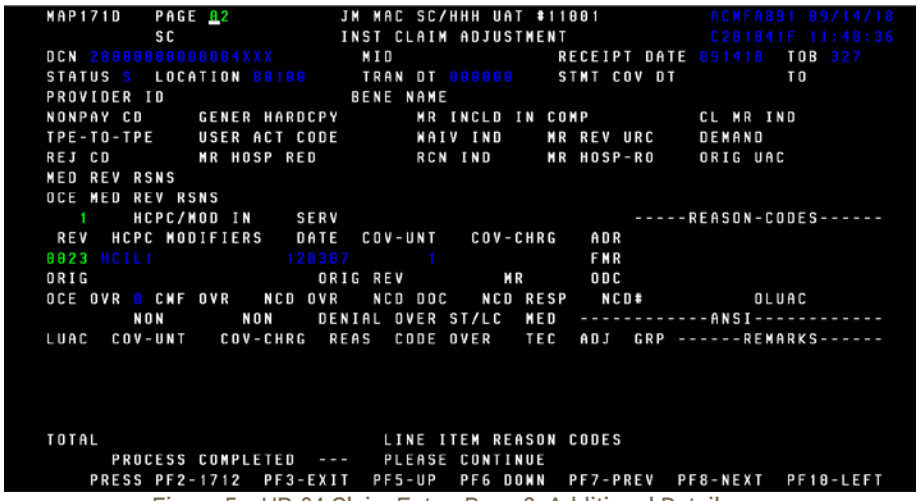

Figure 5 – UB-04 Claim Entry, Page 2, Additional Detail

If a claim has been denied with a full denial, the provider cannot submit an adjustment through DDE. Any attempted adjustments will reject with Reason Code 30940 (a provider is not permitted to adjust a fully medically denied claim). If a claim has been fully denied for medical necessity reasons, no adjustments can be submitted. If the claim was partially denied for medical

necessity, a provider may adjust the claim, but may only change/delete/add line items that were not denied.

To access the claim and make the adjustment:

1. Select the option on the Claim and Attachments Correction Menu for the type of claim to be adjusted and press **[ENTER]**. End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB.
2. Enter the Beneficiary's Medicare number and the FROM and TO dates of service, and then press **[ENTER]**. The system will automatically default the TOB frequency to an XX7. The Medicare number field is now protected and may no longer be changed.
3. Indicate why you are adjusting the claim by entering the claim change condition code on Page 01 of the claim and a valid Adjustment Reason Code on Page 03. Valid Adjustment Reason Codes can be found typing '**16**' in the '**SC**' field in the upper left hand corner of the screen and pressing **[ENTER]**. Press **[ENTER]** again to view the entire list of valid codes and descriptions. If you wish to view the description of a code you want to use, enter the code in the 'Reason Code' field.
4. Give a short explanation of the reason for the adjustment in the remarks section on Page 04 of the claim.
5. To back out without transmitting the adjustment, press **[F3]**. Any changes made to the screens will not be updated.
6. Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. Claims being adjusted will still show on the claim summary screen. Always check the inquiry claim summary screen (option 12) to affirm location of the claim being adjusted.
7. Check the remittance advice to ensure that the claim adjusted properly.

5.B.2. Claim Voids/Cancels

Using the Claim Cancels option, providers can cancel previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter 'P' and is recorded on the claim status inquiry screen. **A claim cannot be voided (canceled) unless it has been finalized and is reflected on the remittance advice.**

Providers must be very careful when creating cancel claims. If you go into the cancel option, be certain that you want to cancel the claim. If you do not want to cancel the claim after you have accessed it, hit [F3] to go back to the claims correction menu. Once you hit [F9], the cancel will be created and process through the system. This will cause payment to be taken back unnecessarily. Once a claim has been voided (canceled), no other processing can occur on that bill.

Important notes on cancels:

- All bill types can be voided except one that has been denied with full or partial medical denial.
- Do not cancel TOB XXP (PRO adjustments) or XXI (Medicare contractor Adjustments).
- A cancel bill must be made to the original paid claim.
- Providers may not reverse a cancel. Canceling a claim in error will cause payment to be taken back by the Medicare contractor.
- Providers may/should add remarks on Claim Page 04 to document the reason for the cancel.
- After the cancel has been stored, the claim will appear in Status/Location S B9000.

- Cancels do not appear on provider weekly monitoring reports; therefore, use the Claim Summary Inquiry to follow the status/location of a cancel.

To access the claim and cancel it:

1. Select the option on the Claim and Attachments Correction Menu for the type of claim to be canceled and press **[ENTER]**. End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB.
2. Enter the Beneficiary's Medicare number and the FROM and TO dates of service, and then press **[ENTER]**.
3. Select the claim to be canceled by typing an '**S**' in the '**SEL**' field beside the first line of the claim and then press **[ENTER]**. The Medicare number field is now protected and may no longer be changed.
4. Indicate why you are voiding/canceling the claim by entering the claim change condition on Page 01 of the claim.
5. Give a short explanation of the reason for the void/cancel in the remarks section on Page 04 of the claim.
6. To back out without transmitting the void/cancel, press **[F3]**. Any changes made to the screens will not be updated.
7. Press **[F9]** to update/enter the cancel claim into DDE for reprocessing and payment retraction.
8. Check the remittance advice to ensure the claim canceled properly.

5.B.3. Valid Claim Change Condition Codes

Adjustment condition code will be needed to indicate the primary reason for initiating an on-line claim adjustment or void/cancel. Valid code values include:

D0 = Changes to service dates
D1 = Changes to charges – **Note**: When there are multiple changes to a claim in addition to changes to charges, the D1 "changes to charges" code value will take precedence.
D2 = Changes to Revenue Codes/HCPCS
D3 = Second or subsequent interim PPS bill
D4 = Change in GROUPER input
D5 = Cancel only to correct a Beneficiary's Medicare number or Provider identification number – **For XX8 TOB only**
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill) – **For XX8 TOB only**
D7 = Change to make Medicare the secondary payer (use only *when the original Medicare payment amount will change)*
D8 = Change to make Medicare the primary payer (*use only when the original Medicare payment amount will change)*
D9 = Any other change (Use this code only if no other code applies. Adjusted claims submitted with this condition code are manually reviewed and remarks must be entered on the claim.)
E0 = Change in patient status