Denials – When To Submit a Corrected Claim vs. an Appeal

Corrected claim submission

If we deny a service for missing or incorrect information, and you agree with our decision and want to submit a corrected claim, then:

- Follow our *Process for Submitting Claims Corrections*. It can be found online. Log in at **hap.org**, select *Quick Links*, then *Billing Manual*.

Important!

Providers have one (1) year from the date of service to submit a corrected claim.

Denials include, but are not limited to:

- Incorrect date of service
- Incorrect diagnosis or ICD-10 Manual guidelines not followed
- Missing NDC
- Inaccurate CPT/HCPCS/REV code
- Missing modifiers or incorrect modifiers (with the exception of the modifiers listed below), such as anatomical, DME, therapies,
- Over billed units

Appeals

If you disagree with the denial and submitting a corrected claim will not resolve the issue, then:

- Submit an appeal letter and medical records within 60 days of the original denial date
- Do **not** keep submitting corrected claims to resolve a denial issue
- The denial must be resolved on the original claim.

You can find the appeals process online. Log in at **hap.org**, select *Quick Links*, then *Billing Manual*.

Denials include, but are not limited to:

- Mutually exclusive procedures
- Units billed appropriately
- Exceeds clinical guidelines
- Included in the global surgical package
- Modifier missing – see list of modifiers below

Missing Modifiers Requiring Appeal and Corrected Claim

If we deny a service for an unsupported modifier or you determine modifiers 24, 25, 27, 57, 59, 76, 91, XE, XS, XP, or XU should have been billed, then:

- Submit an appeal with medical records and a hard copy corrected claim.
- Do **not** just add a modifier on the claim that would bypass the edit/denial. This may cause the service to be denied again.

Important!

- Modifiers XE, XS, XP, and XU give greater reporting specificity in situations where you used modifier 59 previously. Use these modifiers instead of modifier 59 whenever possible.
- Only use modifier 59 if no other, more specific, modifier is appropriate.
- All modifiers must be supported in the medical records.