Corrected Claim Reimbursement Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Passport by Molina Healthcare reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy

A corrected claim needs to be submitted when incorrect coding or missing information prevents Passport Health plan from correctly processing the claim.

Examples of Corrected Claim
Missing, Updated or Invalid Modifier
Missing, Updated or Invalid CPT/HCPCS/Revenue/NDC Codes
Missing Information, e.g., EOB, Consent/Necessity Form, Invoice or MSRP/Medical Records
Any other changes to the claim that is being correct, e.g., charges, units, etc.

Providers have the option to rectify any necessary information on the CMS-1500 and UB-04 forms. Corrected claims are treated as new claims for processing purposes. Providers can submit corrected claims via paper or electronically through the EDI (Electronic Data Interchange) clearinghouse and/or the Provider Portal. When submitting, ensure that all appropriate fields on the 837I or 837P are completed. The Provider Portal offers the functionality to submit corrected Institutional and Professional claims.

Corrected claims must contain the accurate coding to indicate whether they are a replacement of a prior claim or a corrected version of an 837I, or the correct resubmission code for an 837P. Claims submitted without the correct coding will be returned to the Provider for resubmission. All corrected claims:

- Must be free of handwritten or stamped verbiage (paper claims).
- Must be submitted on a standard red-colored UB-04 or CMS-1500 claim form (paper claims).
- Claim number being corrected must be inserted in field 64 of the UB-04 or field 22 of the CMS-1500 of the paper claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the UB-04 and 22 of the CMS-1500.

  Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 claim forms or the UB (Uniform Billing) Editor (Uniform Billing Editor) for UB-04 claim forms.

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Frequency Code Indicates the claim is a correction of a previously submitted and adjudicated claim. Providers should use one of the following:

• 1 — Original Claim
• 7 — Replacement of Prior Claim
• 8 — Void/Cancel Prior Claim

Reimbursement

Passport employs the following bill types to facilitate the reversal of payments made through claims, specifically Bill Type xx8. This bill type is utilized to cancel an original paid claim and involves a single action: voiding (reversing) the initial claim. The purpose of using xx8 is to achieve the following:

- cancel an entire payment made on a paid claim.

Passport uses the following bill types for Adjusting previous paid claim by using claims bill type xx7- this type of claim is used to revise information on a previously paid claim. It consists of two actions: the reversal of an original claim and a replacement of that claim. Use xx7 to revise information for any field EXCEPT the following:

- pay-to provider number submitted in error on the original paid claim.
- Passport member consumer ID submitted in error on the original paid claim.
- bill type submitted in error on the original paid claim.

The key fields used in the 5010X22x 837 for adjustments are.

- CLM05-3 Frequency code (last digit) of the Bill type the data in this field will always be 'xx7' or 'xx8'
- 2300 REF=F8 Original Reference Number REF01=F8 REF02=internal control number (ICN-Passport Claim Number) for the claim that is being voided/Reversed or replaced '

	Form Type	Form Locator	
Type of Bill	UB04	FL4	3rd Digit • 7 (Adjustment) • 8 (Reversals/Void)
Document Control Number	UB04	FL64	Refer the previous Paid Passport Claim Number or Provider Control Number
Adjustment or Reversal	1500	FL22	Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. • 7 (Adjustment) • 8 (Reversals/Void)

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Corrected claims filed beyond federal, state-mandated, or company standard timely filing limits will be denied as outside the timely filing limit. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a corrected claim was filed within the applicable filing limit.

Medicare	
State	**Timely Filing for Corrected Claims**
Arizona	Corrected Claims must be sent within 30 days of the original remittance advice date.
California	Corrected Claims must be sent within 365 calendar days of the most recent adjudicated date of the claim
Florida	Corrected Claims must be sent within one year of the date of service of the claim
Idaho	The timeframe for the Corrected Claims submission is the same outlined for the initial submission of claims. The timeframe requirement is measured from the original date of service and can be found in your Provider Service Agreement
Kentucky	Corrected Claims must be sent within 365 calendar days of the date of service of the claim
Massachusetts	Corrected claims must be sent within 30 calendar days or the original claims remittance advice (RA) date
Michigan	Corrected Claims must be sent within 365 calendar days from the date of service or within 90 days of the most recent adjudicated date of the claim
New Mexico	Corrected Claims must be sent within 365 calendar days of Date of Service of the Claim
New York	Corrected Claims must be sent within 30 calendar days or the original Claim Remittance Advice (RA)
Ohio	Corrected Claims must be sent within 365 calendar days of the most recent Paid date of the claim
South Carolina	Corrected Claims must be sent within 365 calendar days of date of service or most recent adjudicated date of the claim.
Texas	Corrected Claims must be sent within 365 calendar days of date of service of the claim
Utah	The timeframe for the Corrected Claims submission is the same outlined for the initial submission of claims. The timeframe requirement is measured from the original date of service and can be found in your Provider Service Agreement
Virginia	Corrected Claims must be sent within 30 days of the original remittance advice date.
Washington	Corrected Claims must be sent within <<24Months>> original claim remittance advice

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Medicaid	
State	**Timely Filing for Corrected Claims**
California	Corrected Claims must be sent within 90 calendar days of the claim.
Florida	Corrected Claims must be sent within 6 months of date of service or most recent adjudicated date of the claim
Idaho	The timeframe for the Corrected Claims submission is the same outlined for the initial submission of claims. The timeframe requirement is measured from the original date of service and can be found in your Provider Service Agreement.
Illinois	Corrected Claims must be sent within 180 calendar days of most recent adjudicated date of the claim
Kentucky	Corrected Claims must be sent within 365 calendar days of the date of service of the claim
Michigan	Corrected Claims must be sent within 365 calendar days from the date of service or within 90 days of the most recent adjudicated date of the claim.
Mississippi	Corrected Claims must be sent within 90 calendar days of the date on the remittance Advice.
Nevada	Contracted Providers: within 180 days from late of service and Non-Contracted Providers: within 365 days from date of service
New York	Providers must submit corrected claims within sixty (60) days of receiving the remittance advice
Ohio	Corrected Claims must be sent within 365 calendar days of the most recent paid date of the claim.
South Carolina	Corrected Claims must be sent within 365 calendar days of service of the claim
Utah	The timeframe for the Corrected Claims submission is the same outlined for the initial submission of claims. The timeframe requirement is measured from the original date of service and can be found in your Provider Service Agreement.
Virginia	Corrected Claims must be sent within 180 calendar days of the original claim paid date
Washington	Corrected Claims must be submitted within 24 months of the original claim remittance advice date.

Marketplace	
State	**Timely Filing for Corrected Claim**
California	Corrected Claims must be sent within 365 calendar days of the most recent adjudicated date of the claim
Florida	Corrected Claims must be sent within six (6) months of the Date of Service of the claim
Idaho	Corrected Claims must be sent within 180 Calendar days of the Date of Service of the claim
Illinois	Corrected Claims must be sent within 180 calendar days of the adjudicated date of the claim
Kentucky	Corrected Claims must be sent within 365 calendar days from date of service or discharge.
Massachusetts	Corrected Claims must be sent within 30 calendar days of the original claims remittance advice (RA) date
Michigan	Corrected Claims must be sent within 365 calendar days from the date of service or within 90 days of the most recent adjudicated claim.
Mississippi	Corrected claims must be sent within 90 calendar days of the Date of Service or most recent adjudicated date of the claim.
New Mexico	Corrected claims must be sent within 90 calendar days of the Date of Service of the claim
Ohio	Corrected Claims must be sent within 365 calendar days of the most recent paid date of the claim

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South Carolina	Corrected Claims must be sent within 365 calendar days from the date if service
Texas	Corrected Claims must be sent within 95 calendar days of the most recent adjudicated date of the claim
Utah	The timeframe for the Corrected Claims submission is the same outlined for the initial submission of claims. The timeframe requirement is measured from the original date of service and can be found in your Provider Service Agreement.
Washington	Corrected Claims must be sent within 180 calendar days of most recent adjudicated date of the claim
Wisconsin	Corrected Claims must be sent within 180 calendar days of the claim

Documentation History

Type	Date	Action
Effective Date	11/03/2022	New Policy
Revised Date		

References

This policy has been developed through consideration of the following:

- CMS
- State Medicaid Regulatory Guidance
- State contract
- Molina Provider Manual