Corrected Claims Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's 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 a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of 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 Overview

If coding errors or missing information are preventing Molina Healthcare Plan from processing your claim accurately, a corrected claim is necessary. Providers have the option to rectify any necessary fields on the CMS1500 and UB-04 forms. Corrected claims are treated as new claims for processing purposes and can be submitted either in paper format or electronically via EDI (Electronic Data Interchange) clearinghouse and the Provider Portal. When submitting corrected claims, ensure that the appropriate fields on the 837I or the 837P are completed.

Please note that corrected claims must include the proper coding to indicate whether they are replacements for prior claims (837I) or corrected claims (837P) and must reference the original claim number.

Claims lacking the correct coding will be returned for resubmission.

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.

Important guidelines for corrected claims:

- Paper claims must be free of handwritten or stamped content.
- Paper claims should be submitted on standard red-colored UB-04 or CMS-1500 forms.
- For paper claims, insert the original claim number in field 64 of UB-04 or field 22 of CMS-1500. For electronic submissions, use the applicable 837 transaction loop.
- Include the appropriate frequency code/resubmission code in field 4 of UB-04 and 22 of CMS-1500.

Frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS1500 claim forms or the UB (Uniform Billing) Editor for UB-04 claim forms. These codes indicate whether the claim is a correction of a previously submitted and adjudicated claim, with options including:

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

Reimbursement Guidelines

Molina utilizes specific bill types for handling adjustments and reversals of previously paid claims:

- Bill Type 'xx8': This bill type is employed to cancel an original paid claim. It involves a single action, which is to void (reverse) the original claim. Use 'xx8' for the following purpose:
    - Cancel an entire payment made on a paid claim.

- Bill Type 'xx7': This bill type is utilized to adjust information on a previously paid claim. It encompasses two actions: reversing the original claim and replacing it with corrected information. Use 'xx7' to revise any field except for the following:
    - Pay-to provider number submitted in error on the original paid claim.
    - Molina member consumer ID submitted in error on the original paid claim.
    - Bill type submitted in error on the original paid claim.

Key Fields for Adjustment Claims:
In adjustment claims using the 5010X22x 837 format, the key fields are as follows:

- CLM05-3: Frequency code (last digit) of the Bill type, which will always be 'xx7' or 'xx8.'
- 2300 REF=F8: Original Reference Number, with REF01=F8 and REF02 being the internal control number (ICN-Molina Claim Number) for the claim that is being voided, reversed, or replaced.

Please Note:

- Adjustments and voids apply exclusively to previously paid claims, including zero-paid claims. Resubmitting a denied claim does not fall under the category of adjustments.

	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 Molina 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)

Claims that are corrected and submitted after the federally, state-mandated, or company-defined timely filing limits will be denied due to exceeding the specified time frame. Services denied failing to meet timely filing requirements will not be eligible for reimbursement unless the provider can provide documentation demonstrating that a corrected claim was indeed submitted within the designated filing deadline.

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
Washington	Corrected Claims must be sent within <<24Months>> original claim remittance advice

Medicaid	
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 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
Iowa	365 days from the last adjudication date up to two years from the date of service
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
Texas	Corrected claims timely filing is 120 days from the payment or denial date. Note: If the 95th or 120th day falls on a weekend or a holiday, the filing deadline is extended to the next business day
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 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
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

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
CMS-1500 (837P) Form	Used for billing professional claims for physicians and non-physician practitioners; it can also be used for billing drugs and durable medical equipment associated with the professional visit.
CPT Codes	Current Procedural Terminology. Used by physician offices and physicians and clinicians in all settings, outpatient hospital facilities, outpatient dialysis centers, and ambulatory surgery centers. CPT codes are used to report most procedures on claims that are sent.
EOB	Explanation of Benefits (EOB). A statement from a health insurance company that explains what medical services were billed, what the insurer paid, and what costs the patient may still owe. It is not a bill, but a summary of how a claim was processed.
HCPCS Codes	Used by physician offices, outpatient hospital facilities, inpatient, outpatient dialysis centers, and ambulatory surgery centers. Medicare mandates that providers (regardless of the type of provider) use alphanumeric HCPCS codes to report various biologicals, drugs, devices, supplies, and certain services.
MSRP	Manufacturer's Suggested Retail Price. The price a drug manufacturer recommends as the retail selling price for a medication identified by its National Drug Code (NDC).
NDC	National Drug Codes. The U.S. Food and Drug Administration (FDA) issues and regulates National Drug Codes (NDCs), which are unique identifiers for drugs marketed in the United States. Each NDC provides information about the manufacturer or labeler, the specific drug product, and the package size or type. The FDA's Center for Drug Evaluation and Research (CDER) maintains the official NDC Directory.
NUCC	NUCC stands for "National Uniform Claim Committee". It is an organization responsible for designing and maintaining the CMS-1500 health insurance claim form. NUCC works directly work with CMS (Centers for Medicare and Medicaid Services) as a key partner in standardizing medical billing data across the healthcare industry.
Revenue Codes	Revenue codes are numerical codes used by healthcare facilities and hospitals to categorize and bill for services provided to patients. Revenue codes help healthcare providers specify the type of service, procedure, or item provided. Revenue codes are used in conjunction with ICD-10-CM codes (for diagnoses) and CPT or HCPCS codes (for procedures and services) to create a complete billing record.
Type of Bill (Bill Type)	A 3-digit code that tells the payer what type of facility is billing, what type of care was provided, and whether it's original, corrected, or final bill.
UB-04 (837I) Form	Used for billing institutional claims for inpatient and outpatient services at hospitals, ambulatory surgery centers, cancer treatment centers, dialysis centers and skilled nursing facilities; it can also be used for billing drugs and durable medical equipment associated with the institutional visit.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	11/20/2020	New Policy
Revised Date	09/01/2023	Updated formatting
Revised Date	04/09/2025	Added remittance advice information to Medicaid section for Arizona.
Revised Date	04/28/2025	Added information regarding Texas Medicaid deadline for corrected claims.
Revised Date	06/04/2025	Added information regarding Iowa Medicaid deadline for corrected claims.
Revised Date	08/05/2025	Update Template and Texas Medicaid guidance
Revised Date	08/22/2025	Changed Coding Disclaimer from 9 point font to 10 point font; deleted out references to Virginia. Updated pages and PI to 10 point font.

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*