PASSPORT BY MOLINA HEALTHCARE

Payment Policy 42
Corrected Claims

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Passport by 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 may 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.

Policy Overview

A corrected claim is submitted by the provider when incorrect coding or missing information is identified.

Examples of Corrected claims:

- 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 corrected, e.g., charges, units, etc.

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.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original claim number will not be adjusted.

Corrected claim information submitted via EDI submission are required to follow electronic claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for compliance SNIP levels 1 to 5. The 837claim format allows you to submit changes to claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "claim frequency codes. Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim. Use the below frequency codes for claims that were previously adjudicated.

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.

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

- 7 - Replacement of Prior Claim
- 8 - Void/Cancel Prior 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 ID submitted in error on the original paid claim
- bill type submitted in error on the original paid claim

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 the entire payment made on a 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

Reimbursement Guidelines

Reimbursement is based on the applicable fee schedule or contracted/negotiated rate.

Claims must be submitted by provider to Passport within 365 calendar days after the discharge for inpatient services or the date of service for outpatient services unless otherwise specified in a provider's contract. If Passport is not the primary payer under coordination of benefits or third-party liability, provider must submit claims to Passport within 365 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by Government Program requirements, any claims that are not submitted to Passport within these timelines shall not be eligible for payment and provider hereby waives any right to payment.

Audit and Recovery Process:

- **Review:** Claims will be meticulously examined against Passport by Molina Healthcare's standards.
- **Discrepancy Identification:** Any inconsistencies or errors identified will be documented.

- **Recovery:** Overpayments due to inaccuracies will be recovered either by offsetting from future payments or through direct refund requests.
- **Appeals:** Providers reserve the right to contest any claim adjustments or denials. Details of the appeal process will accompany the notification.

Policy Monitoring, Review, and Updates:

- The policy will undergo annual reviews or as required, ensuring its alignment with industry best practices, regulatory mandates, and Passport by Molina Healthcare's operational necessities. Any updates will be promptly communicated to providers.

Supplemental Information

Please note, Passport has followed and enforced these guidelines, in accordance with applicable regulations, since inception on January 1, 2021. For this specific policy, the publication date is merely the date the policy was formally memorialized.

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Corrected Claim	A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.).

Documentation History

Type	Date	Action
Effective Date	12/3/2022	New Policy
Revised Date	9/12/2024	Updated policy to add clarifying language Updated to add definitions Updated references to be KY specific and to provide links

References

1. Passport By Molina Provider Manual
   Link: PROVIDER MANUAL (Provider Handbook) (molinahealthcare.com)
2. Uniform Billing Editor
3. Medicare Claims Processing Manual (cms.gov) Section 10.4.1
4. Revised 1500 Claim Form Instructions (molinahealthcare.com)

This policy is designed to provide guidance and is not a guarantee of payment. Healthcare providers should make medical necessity determinations based on the individual clinical circumstances of each patient.