Reimbursement Policy for Corrected Claims

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 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 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 CMS-1500 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 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 CMS-1500 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:

1. 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.

2. 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.
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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.
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.	**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 for 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
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

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
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
Published	11/03/2022	New Policy
Revised Date	09/01/2023	Updated formatting

State Exceptions

State	Exception

References

This policy has been developed through consideration of the following:

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