



**L.A. Care**  
HEALTH PLAN®

**For All of L.A.**

# CLARIFICATION ON SUBMITTING CORRECTED CLAIMS

## BILLING A CORRECTED CLAIM SUBMISSION REQUIREMENTS

In an effort to clarify corrected claims billing guidelines, ensure providers receive appropriate reimbursement, and avoid denied claims, L.A. Care Health Plan (L.A. Care) requests that you adhere to the following billing requirements outlined in this document when submitting corrected claim(s).

## WHAT IS A CORRECTED CLAIM?

A corrected claim is a replacement of a previously billed claim that requires revisions to coding, service dates, billed amounts, or member information.

## CORRECTED CLAIM TIMELY SUBMISSION REQUIREMENTS

Timeliness must be adhered to for the proper submission of a corrected claim. The deadline for submitting a corrected claim is 365 days from the date of initial determination.

## CORRECTED CLAIM BILLING REQUIREMENTS

When submitting a corrected billing claim on a CMS-1500, UB04, and/or through Electronic Data Interchange (EDI), your practice should include the following information to ensure accurate processing of the claim.

## CLARIFICATION ON CORRECTED CLAIM BILLING REQUIREMENTS

Providers must submit the L.A. Care Claim Number that requires correction. If a provider is correcting a claim that has already been adjusted/reprocessed, the correct iteration of the claim being corrected must be included in the Plan CRN field. In other words, if you are correcting a claim number ending with an A1, the Plan CRN must include the A1.

## CMS-1500 or UB04 CORRECTED CLAIM SUBMISSION

### For CMS-1500 Claim Form

- Stamp "Corrected Claim Billing" on the claim form
- Use billing code "7" in box 22 (Resubmission Code field)
- Payers **original claim or latest adjusted claim number** should also be included in box 22 under the "Original Ref No." field.

20. OUTSIDE LAB?	§ CHARGES
<input type="checkbox"/> YES <input type="checkbox"/> NO	
22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	180XXXXXXXXXX
23. PRIOR AUTHORIZATION NUMBER	

### For UB04 Claim Form

- The fourth digit of the "Type of Bill" (field 4) should be "7"

3a PAT. CNTL #	4 TYPE OF BILL	
b. MED. REC. #	XX7	
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH

- Include the original claim or latest adjusted claim number in box 64 (Document Control Number)

64 DOCUMENT CONTROL NUMBER
108XXXXXXXXX

Corrected claims should include all previously billed line items, not just the lines or data that requires correction.



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### 837I/P CORRECTED CLAIM SUBMISSION REQUIREMENTS

Claims submitted electronically should include claim frequency codes that alert the system that the claim is a correction to a previously approved or denied claim. The claim frequency codes are as follows:

- 1 – Original Claim
- 7 – Replacement or Corrected Claim
  - Information on this bill indicates a replacement of the original claim
- 8 – Voided or Canceled Claim

#### **Professional Claims – 837P Billing Requirements**

Loop 2300

- CLM05-3 = Frequency Type Code “7”
- REF01 = F8 (Original Reference Number)
- REF02 = Original payer’s original claim or latest adjusted claim number

#### **Institutional Claims – 837I Billing Requirements:**

Loop 2300

- CLM05-3 = Frequency Type Code “7” (4<sup>th</sup> digit of the Type of Bill code)
- REF01 = F8 (Original reference number)
- REF02 = Original payer’s original claim or latest adjusted claim number

**CLM\*12345678\*500\*\*\*11:A:7\*Y\*A\*Y\*I~**  
**REF\*F8\*180XXXXXXXXX ~**

If you have any questions, please contact your assigned Account Manager.

Thank You,

L.A. Care Claims Department