CLARIFICATION ON SUBMITTING CORRECTED CLAIMS

L.A. Care HEALTH PLAN®

For All of L.A.

BILLING A CORRECTED CLAIM SUBMISSION REQUIREMENTS

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

WHAT IS A CORRECTED CLAIM?

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

CORRECTED CLAIM TIMELY SUBMISSION REQUIREMENTS

Timeliness must be adhered to for proper submission of corrected claim. Corrected claim timely filing submission is 365 days from the date of initial determination.

CORRECTED CLAIM BILLING REQUIREMENTS

When submitting a claim for corrected billing on a CMS-1500, UB04, and/or electronically (EDI) your practice should include the following information to allow for accurate processing of your corrected claim.

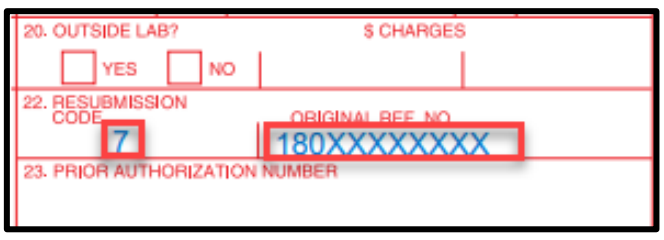
CLARIFICATION ON CORRECTED CLAIM BILLING REQUIREMENTS

Providers must submit the L.A. Care Claim Number that requires correction. If 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

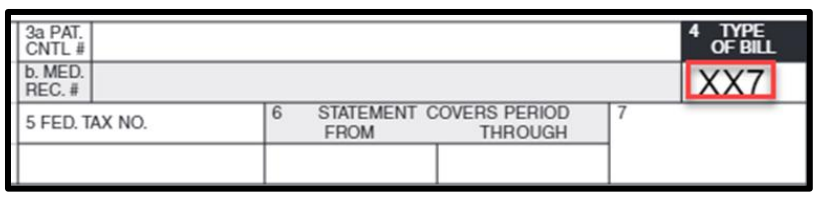
For CMS-1500 Claim Form

- 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.

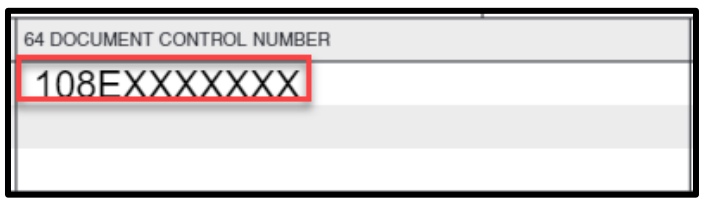


For UB04 Claim Form

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



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



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

837I/P CORRECTED CLAIM SUBMISSION REQUIREMENTS

Claims submitted electronically should include claim frequency codes that alert the system to know that the claim is a correction to a previously approved or denied claim. 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" (4th 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