If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Oklahoma may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Corrected Claim Submissions

Policy Number: CPCP025

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: December 24, 2024

Plan Effective Date: January 2, 2025

Description

A corrected claim is used to update a previously processed claim with new or additional information. A corrected claim is member and claim specific and should only be submitted if the original claim information was incomplete or inaccurate. All changes must be submitted through electronic or paper submissions and not by calling the Plan. A corrected claim does not constitute an appeal.

Corrected Claim Submission Guidelines

Corrected claim submissions should be minimal. The Plan urges providers to submit claims once all charges are documented to reduce claim processing errors and duplicate filing. Corrected claims must still be filed within the timely filing deadlines. Note, a correction to a prior claim may not be submitted until the original claim has been processed and provider has been notified of the claim status.

Acceptable reasons for corrected claims include, but are not limited to, the following:

- Replacing the previous or original claim with a correction, addition or removal of charges for services (e.g., update of diagnosis code, procedure code, modifier update, units billed)
- Update to billed charges - Billed charges must comply with applicable law. An increase in billed charges for line items from the original claim without adequate justification is not considered a corrected claim and may result in a claim review.
- Cancellation of the previous or original claim submitted
- Date of service correction
- Provider ID# correction

When submitting a corrected claim, required information is needed to support the change(s) to an incorrect or incomplete claim submission previously processed. All accurate line items from the original submission must appear on the replacement claim along with the line items requiring a correction to avoid unintended refund or overpayment requests. In some cases, medical records may be required to justify corrections to diagnosis codes, DRGs, procedure codes, medication units, modifiers, or other modifications. Examples of supporting documentation include, but are not limited to: medical records, copy of the original claim, and documentation reflecting a procedure was repeated on the same day.

Corrected Claims Submission

A corrected claim should be submitted as an electronic replacement claim or on a paper claim form along with a *Corrected Claim Review Form* (available on the provider tab of the Plan's website). The corrected claim should include all line items previously processed correctly. Reimbursement for line items no longer included on the corrected claim may be subject to recoupment by the Plan.

Corrected Claims for Late Charges

Late charges, or additional charges, represent changes for items and services that were submitted after the bill was created and not included in the original bill. All late charges must be submitted as a corrected claim after the original claim has been processed. When submitting a corrected claim to add late charges to an inpatient or outpatient claim submission of the entire claim (original values and late/additional charges) should be resubmitted with frequency code 7 (Replacement of Prior Claim). Do not submit a corrected claim using frequency code 5 (Late Charges). If the corrected claim is submitted using frequency code 5 this could result in a denial of the claim. If a claim review has been performed, the overpayment amount is calculated based on the review findings. Only corrected charges (both unbilled and incorrectly billed) identified during the review may be submitted on a corrected claim post review. Provider may still be obligated to refund an overpayment of charges identified by the claim review if such charges are not removed from the corrected claim.

Electronic Submission

The Plan's claim system recognizes electronic claim submissions by the frequency code. The ANSI X12 837 claim format permits 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". **All corrected claim submissions should contain the original claim number or the Document Control Number/DCN.**

Paper Submission

When submitting a paper claim, Professional providers should use Form CMS-1500 (version 08/05) and Institutional providers should use Form UB04.

Frequency codes for CMS-1500 Form box 22 (Resubmission Code) or UB04 Form box 4 (Type of Bill) should contain a **7** to replace the frequency billing code (corrected or replacement claim), or an **8** (Void Billing Code). **All corrected claim submissions should contain the original claim number or the Document Control Number.**

Note: The Plan requires an NPI number and paper claims may be denied if filed with only the Plan's provider number. Paper claims that are rejected / denied will be returned with a cover letter explaining the reason for return. Providers can obtain additional information about the CMS-1500 claim form by visiting the National Uniform Claim Committee website located in the references below.

Frequency Codes

FREQUENCY CODE	DESCRIPTION	SUBMISSION GUIDELINES	ACTION
7 - Replacement of Prior Claim	Use when replacing the entire claim (all but identity information).	File electronically, as usual. File the claim in its entirety, including all services for reconsideration, such as: • Patient's last name, first initial • Member ID number • DCN of the original claim submission • Claim change reason code(s) as a condition code • Brief description of the correction	The Plan will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.

FREQUENCY CODE	DESCRIPTION	SUBMISSION GUIDELINES	ACTION
		being made in the Remarks Field	
8 - Void/Cancel of Prior Claim	Use to entirely eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."	File electronically, as usual. Include all charges submitted on the original claim. The following is required information and must match the original paid claim: • Patient's last name, first initial • Member ID number • DCN number • Claim change reason code(s) or condition code(s) • Reason for voided or cancelled claim in the Remarks field and the dates of service to be cancelled	The Plan will void the original claim from records based on this request.

Electronic replacement claims submitted with claim frequency code **7** or **8** with the original claim number, or the DCN must be submitted in Loop 2300 REF02- Payer Claim Control Number with qualifier F8 in REF01. Failure to submit without the original claim number or DCN will generate a compliance error and the claim will be rejected. The Plan will only accept claim frequency code **7** to replace a prior claim or **8** to void a prior claim.

- **Additional Information for Professional Providers/ Electronic Submissions**

  A claim correction submitted without the appropriate frequency code will deny and the original claim number or DCN will not be adjusted.

- **Additional Information for Institutional Providers/Electronic Submissions**

  A claim correction submitted without the appropriate frequency code will deny as a duplicate and the original claim number or DCN will not be adjusted.

Refer to the Plan's website for the benefits of submitting claims electronically, available vendor partners, guidance, and examples on submitting an electronic replacement claim/corrected claim.

Additional Resources

Clinical Payment and Coding Policy

CPCP029 Medical Record Documentation

References

Provider website document: Electronic Replacement/Corrected Claim Submissions
National Uniform Claim Committee

Policy Update History

Approval Date	Description
04/30/2020	New policy
06/01/2022	Annual Review
12/11/2023	Annual Review, Changes to Claim Frequency Codes effective 07/01/2024
12/24/2024	Annual Review