BlueCross BlueShield of Texas

CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) 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. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX 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 (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) 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 2.0
Clinical Payment and Coding Policy Committee Approval Date: April 30, 2020
Plan Effective Date: August 15, 2020 (Blue Cross and Blue Shield of Texas Only)

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. A corrected claim does not constitute an appeal.

Corrected Claim Submission Guidelines:

Corrected claim submissions should be minimal.

To submit 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:

- Medical records
- Copy of the original claim
- Documentation reflecting a procedure was repeated on the same day

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

- Addition of late charges to an inpatient or outpatient claim when the original claim has been processed*
- 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**
- Cancellation of the previous or original claim submitted
- Date of service correction
- Provider ID# correction

*When submitting late charges to an inpatient or outpatient claim when the original claim has been processed, submission of the entire claim (original values and late charges) should be resubmitted with the appropriate frequency code. If only late charges are submitted (not including original values) this could result in a denial of the claim. If a Hospital Charge Audit (itemized bill review) has been performed, the only late charges that may be submitted post review, are those that were identified during the review.

**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.

Note: If a review of a claim has been performed:

- The overpayment amount will be calculated based on the review findings;
- A corrected claim will not preclude the requirement to refund an overpayment where that overpayment has not been addressed in the corrected claim.

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.

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 (DCN).

*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
5 - Late Charge(s) (Institutional Providers Only)	Use to submit additional charges for the same date(s) of service on a previous claim.	File electronically, as usual. Include only the additional late charges that were not included on the original claim.	The plan will add the late charges to the previously processed claim.
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.	The plan will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
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 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.

References:

Provider website document: Corrected Claim Submissions - https://www.bcbstx.com/provider/pdf/corrected-claim-submissions.pdf

National Uniform Claim Committee - www.nucc.org

Policy Update History:

Approval Date	Description
09/27/2019	New policy
01/16/2020	Policy name revision from CPCPG025, Disclaimer update
04/30/2020	Verbiage edits

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