Administrative Simplification
Operational Guidelines & Link to Cover Sheet

Simplification Area: Claims Processing

Topic: Submitting Corrected Claims

Objective: Quicker turnaround of corrected claims

Expected Impact: *Hospitals & Medical Practices:* Some corrected claims are rejected in error by the health plan as duplicates. In these cases, billing staff spends about 15 minutes per claim to contact the health plan and resend the corrected claim and associated materials.

By using the Standard Cover Sheet along with paper claims (or better yet the HIPAA 837 transaction for electronically submitted claims), the timeframe to get a corrected claim to the right place within a health plan, and the resulting payment turnaround time, is likely to be reduced by at least 2 days, and with less risk that the claim will be rejected as a duplicate.

Health Plans – Staff spends at least 3 minutes per call to resolve issues related to corrected claims that were rejected as duplicates.

Synopsis:

A standard cover sheet has been developed for submitting corrected claims on paper. Using this cover sheet will help to ensure that the paper claim is routed to the right place within participating health plans and is not rejected as a duplicate claim.

For the fastest processing,

- ***Submit your claims electronically***

Operational Guidelines:

Upon reviewing a payment voucher, or after conversations with a health plan representative, it may be necessary for a provider to correct the claim and resubmit it. To reduce the risk that the corrected claim will be rejected by the health plan as a 'duplicate' of the first claim, providers should use the following procedures:

Submitting the corrected claim electronically:

The best and most expedient process for submitting corrected claims is to use the 837 transaction. Refer to the Best Practice Recommendation for Electronic Processing of Corrections to Claims that can be found on the OHP website at www. for Professional Claims and www. for Institutional Claims.

If the provider uses a clearinghouse to submit an 837-claim transaction to the health plan, the provider should verify that the clearinghouse will create an 837 that contains the appropriate information about the correction. (For UB-04 based claims, the 'Claim Frequency Type Code' information can be derived from the 'Type of Bill' field.)

Health plans will process these claims as corrected claims rather than rejecting them as duplicate claims.

Submitting the corrected claim on paper:

If the provider organization does not have the ability to electronically submit the corrected claim, the Standard Cover Sheet should be used with CMS 1500 and UB-04 paper claims.

The Corrected Claims – Standard Cover Sheet should be completed and submitted with the corrected paper claim. The corrected UB-04 claim should have the correct type of bill coding that indicates it is a corrected claim. (There is no type of bill field on the CMS 1500 claim.)

This Standard Cover Sheet can be found on the OHP website, http://www.onehealthport.com/admin_simp/claims/SubmitCorrectedClaims-CoverSheet_Rev3-6_form.pdf

- Be sure that the Corrected Claims form is filled out completely **and written clearly (preferably by typing directly into the fields on the .pdf)**.
  - Include the health plan name and, as appropriate, the product line. This will help to ensure that the claim gets to the right department and person in the health plan.
  - **The health plan's claim number associated with your previously submitted claim must be included** in order for the health plan to successfully identify this as a corrected claim.
- Only send supporting documentation that has been specifically requested by the health plan. Sending documentation that has not been requested is likely to slow down the adjudication process
- The Corrected Claims should be sent to the appropriate location at the health plan.
- Health plans will process these claims as corrected claims rather than rejecting them as duplicate claims.