Claim Adjustments

Occasionally, you might need to correct or change information on a claim after it has been processed because the original claim information was wrong or incomplete. You must submit corrections via an 837 electronic adjustment request, using the same claim type as the original (837P, 837I, 837D). If you are changing the claim type, you must submit a new, clean claim. We typically return paper claim corrections except when the correction is for an NPI change (see more information below).

Your adjustment request must include the resubmitted claim (all lines) with corrections, frequency code 7, and the correct original claim ID (this is a character value that must include any leading zeros) in the appropriate EDI loop. For institutional claims, we need admission through discharge information.

- We will do a line-by-line comparison of the adjustment to the original claim.
- The adjustment will be returned if the claim information is incomplete or if frequency code 7 is missing.
- If you want to completely void or cancel the original claim and start over with a new clean claim, use frequency code 8.

When to submit an adjustment

Claim adjustments can *only* be made **after the claim is fully adjudicated** and the remit is available. AZ Blue will reject any adjustments sent before the claim is finalized.

Most claim adjustments must be made within one year from the date the claim was originally processed. Adjustments beyond the one-year period are allowed in the limited circumstances listed in the provider participation agreement, including:

- Claims for services rendered to an FEP member
- Claims involving subrogation and coordination of benefits with Medicare or another private payer (including self-funded employer groups) not governed by state law
- Claims involving “fraud,” which means, without limitation, a claim that includes or is based on a willful misstatement or omission of material fact by a member or provider, resulting in incorrect adjudication of a claim, and includes, without limitation, failure to disclose other applicable coverage, use of CPT® codes that do not accurately reflect services provided, billing for services not rendered, and billing for services under the name of a provider other than the provider who actually rendered the service
- Claims for which a longer period of time is required by applicable state or federal law, including, without limitation, adjustments required because of federally mandated changes in Medicare reimbursement rates, federal requirements that certain government payers be secondary payer or payer of last resort, and federal laws prohibiting providers from accepting more than the Medicare limiting charge
- Claims for which AZ Blue is under a lawful order to adjust a claim because a member or provider has prevailed on a healthcare appeal
- Claims under a workers’ compensation policy

Process date

The process date is the date on which a claim is adjudicated or finalized in our claim processing system. When a claim is adjusted or re-adjudicated, we assign a new process date, and the claim is subject to the current AZ Blue pricing logic.

Claim Adjustments

No claim corrections are permitted once a grievance or appeal is filed
Before submitting a grievance related to a claim, ensure that all information on the claim is accurate. A claim may not be corrected after a grievance or appeal has been filed. Grievances and appeals are carefully reviewed and decisions are based on the premise that all information on the claim is accurate.

Submitting 837 adjustment requests
Do *not* send medical records with the initial adjustment request. If we need records to support a correction, we will request them later. Types of claim information corrections that may be submitted via an 837 adjustment include:

- Patient name
- Place of service
- Date of service
- Billed charge amount
- Member ID
- Number of units
- Other billing
- Anesthesia time
- Adding or changing modifiers
- Change in sequence of diagnosis codes
- Late charges to inpatient or outpatient claims
- Other insurance carrier COB payment

For more details on the submission of electronic adjustments, view or download the Electronic Claim Adjustments – User Guide, available via our Electronic Business page.

AZ Blue plan secondary to Medicare – claim adjustments
For members with Medicare primary coverage and AZ Blue secondary coverage (Medicare Supplement or other applicable AZ Blue plan), submit claim adjustments to the Medicare contractor first.

Workers' compensation (WC) – claim adjustments
For specific procedures to request adjustments to WC claims, see Section 8.

Correcting a provider NPI
If you are correcting a provider NPI, you must use our corrected claim form for each claim that is submitted for adjustment (not an electronic adjustment). To correct an NPI, you must include medical record documentation verifying the rendering provider. The fillable PDF form is available via our Forms page under Claims.

Limitation on the number of adjustments
You are responsible for the completeness and accuracy of submitted claims. We may refuse to accept an adjustment if you have submitted multiple adjustments of the same claim or altered medical records.

Include frequency code 7 or 8 for electronic adjustments
Submit the *entire* claim (for institutional claims, include admission through discharge) electronically as an adjustment, using frequency code 7 to indicate replacement of a prior claim. Without that code, we cannot verify that the request is for a claim adjustment, which could cause the claim to deny as a duplicate claim.

- If you want to completely void or cancel the original claim and start over with a new clean claim, use frequency code 8.
- We will return adjustment requests submitted with incomplete claim information or without frequency code 7 or 8.

Claim Adjustments

The following table shows conditions that must be met for 837 claim adjustments to be processed quickly and accurately:

ASC_X12N/005010X222_A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3								
TR3 Page #			Loop ID	Reference	Name	Codes	Length	Notes/Comments
Professional	*Institutional*	*Dental*						
159	145	147	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	Must = 7 (replacement of prior claim) or 8 (void/cancel prior claim)
196	166	168	2300	REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	Insert "F8"
196	166	168	2300	REF02 Claim Information	Reference Identification	AN	1/30	For AZ Blue Local, FEP (DOS before 8/6/22) CHS, and Medicare Advantage, ICN/DCN must be 15 numeric characters. For FEP (DOS on or after 8/6/22), ICN/DCN must be 12 numeric characters or 12 numeric with one or two alpha characters in the 13th/14th position. For BlueCard (out-of-area) commercial and Medicare Advantage, ICN/DCN must be 15-17 numeric characters.

Notes:

- For NTE02 claim information, we no longer require the adjustment reason and narrative, except when you are submitting a correction to reduce line charges.
- For 837 institutional claim adjustments, we no longer require condition codes associated with adjustment (HI segment).
- Claims originally submitted with frequency code 5 (late charge[s] only) will continue to error.

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