This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), Version 5010.

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1. **Title of best practice:**

   Replacement/Void Claims

2. **Who does the best practice apply to:**

   Both providers and group purchasers

3. **Narrative description as to what is being addressed by this best practice:**

   This best practice document clarifies definitions, identification and handling of replacement and void claim types.

   Replacement claim may also be referred to as corrected claim; void claim may also be referred to as a cancel claim.

4. **The loops, segments and elements, etc. that the best practice applies to:**

   Includes 837 professional, institutional and dental claim formats.
   Loop 2300, CLM05-3

   Loop 2300, REF02 where REF01 value is "F8"

5. **Describe how to do the best practice:**

   <u>This best practice must be used per definitions of replacement and void submissions in section 3.2.3 of the Minnesota Uniform Companion Guides.</u>

   Replacement and Void:

   - The bill frequency in CLM05-3 indicates the claim is an original, replacement or a void. For example, a value of "7" represents a replacement claim and value "8" represents a void claim. For a complete list of values, see code source 235.
   - For a replacement or a void the payer assigned claim number for the last known claim being replaced is sent in Loop 2300, REF02 where REF01 is equal to F8. (NOTE: the original payer assigned claim number is not the property & casualty or workers' compensation claim number.)
   - Replacement or void of prior claim should not be done until prior submitted claim has reached final adjudication status. Final adjudication can be determined from remittance advice, web application or the 277 response. Verify with the group purchaser if a non-finalized claim can be replaced or voided.

- Under the NUBC claim frequency guidelines, when sending a replacement or void claim, the entire original or previous submission must be replaced or voided. If the group purchaser has split the claim, the provider can report only one of the group purchaser claim numbers in the replacement or void claim. It is the responsibility of the group purchaser to identify all split claims that are being replaced or voided. It is acceptable to send void or replacement when any one split claim has reached final adjudication.

Replacements Only:

- A replacement is sent when an element of data on the claim was either not previously sent or needs to be corrected. Examples include incorrect dates of service or units. To qualify for a replacement, certain identifying information must remain the same. If these values change then prior claim must be voided, and a new claim would be sent with the appropriate frequency.
    - provider (2010AA Loop)
    - patient (either 2010BA or 2010CA Loop)
    - payer (2010BB Loop)
    - subscriber (2010BA Loop)
    - institutional statement period (2300, DTP Segment).

Voids Only:

- When identifying elements change, a void submission is required to eliminate the previously submitted claim. The entire claim must match the original with the exception of the claim frequency code, condition code, payer assigned claim number, and the patient control number. EXAMPLES: incorrect provider, patient, payer, insured and statement period on an institutional claim or patient did not want insurer to be billed for services.
    - There is no need to send negative values on a void claim. The claim frequency code indicates that the values are negated.
- If a new original is required after the void, recommend verifying the void is finalized prior to sending new to avoid duplication)

6. **Examples to illustrate best practice: Replacement vs. Void Examples**

Please note the replacement list is not all-inclusive

Replacement	Void
Procedure code missing modifier Line being added Diagnoses code change or addition Procedure code change Revenue code change Change to injury date Change to related cause codes Change to place of service Change to rendering provider with no billing provider change	Payer information change Subscriber information change Billing Provider information change Patient information change Statement covers period Patient did not want insurance billed (note: no new original should be sent) Bill type changes from inpatient to outpatient, or outpatient to inpatient

Example of split original claim:

If the original claim was split by the group purchaser into 3 claims with group purchaser claim numbers of 12345, 12346, and 12347, when the provider submits the replacement claim, a complete replacement should be sent which includes services from all 3 split claims. Loop 2300, REF segment with F8 qualifier would contain one of the three claim numbers.

7. **AUC approval date:**

   03/29/2018

8. **Last reviewed date:**

   03/29/2018