10040 Regency Circle, Suite 100
Omaha, NE 68114

Reimbursement Policy	
Subject: **Corrected Claims**	
Policy Number: **G-16001**	Policy Section: **Administration**
Last Approval Date: **07/23/2021**	Effective Date: **07/23/2021**

**** Visit our provider website for the most current version of our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.healthybluene.com**. ****

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Healthy Blue benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed codes are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Healthy Blue reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy to our provider website.

Policy

Healthy Blue allows reimbursement for a corrected claim when received within the applicable timely filing requirements of the original claim in compliance with federal and/or state mandates

regarding corrected claim filing requirements. The corrected claim must be received within the timely filing limit due to the initial claim not being considered a clean claim. In the absence of such mandate, we follow the standard of:

- Within 180 days of the date of service for participating providers and facilities
- Within 180 days of the date of service for nonparticipating providers and facilities

Providers resubmitting paper claims for corrections must clearly mark the claim Corrected Claim. Corrected claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

Corrected claims filed beyond federal, state-mandated, or company standard timely filing limits will be denied as outside the timely filing limit. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a corrected claim was filed within the applicable filing limit.

Healthy Blue reserves the right to waive corrected claim filing requirements on a temporary basis following documented natural disasters or under applicable state guidance.

Note: Corrected claims must be submitted separately for each member and episode of care and cannot be accepted by batch, bulk, or packaged submissions.

Related Coding

Standard correct coding applies.

History

Date	Action
07/23/2021	Biennial review approved and effective 07/23/2021: Policy template updated, updated language to “within 180 days of the date of service” for both participating and non-participating providers and facilities.
01/01/2021	Initial approval and effective date 01/01/2021

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid Agency
- State contracts

Definitions

Term	Definition
Frequency Code	Indicates the claim is a correction of a previously submitted and adjudicated claim; providers should use one of the following: • 1 — Original Claim • 7 — Replacement of Prior Claim • 8 — Void/Cancel Prior Claim
Resubmission Period	Refers to the initial claim timely filing requirements
General Reimbursement Policy Definitions	

Related Policies and Materials

Claims Timely Filing
EDI Claims Companion Guide for Professional Services
Eligible Billed Charges

Requirements for Documentation of Proof of Timely Filing