Reimbursement Policy	
Subject: **Corrected Claims**	
Policy Number: **G-16001**	Policy Section: **Administration**
Last Approval Date: **07/23/21**	Effective Date: **07/23/21**

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://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare.

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Blue Cross and Blue Shield of North Carolina (Blue Cross NC) if the service is covered for Healthy Blue + Medicare℠ (HMO D-SNP). 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 code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Blue Cross NC Medicare Advantage may:

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

Blue Cross NC Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Blue Cross NC Medicare Advantage strives to minimize these variations.

Blue Cross NC Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy our provider website.

Policy

Blue Cross NC Medicare Advantage allows reimbursement for a corrected claim when received within the applicable timely filing requirements of the original claim. Due to the initial claim not being considered a clean claim, the corrected claim must be received within the timely filing limit outlined below unless otherwise stipulated by contract. For participating and nonparticipating providers, Blue Cross NC Medicare Advantage follows the standard of 12 months from the date of service.

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.

Blue Cross NC Medicare Advantage 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.

Policy History

Date	Action
07/23/21	Biennial review approved and effective: Policy template updated
01/01/21	Initial policy approved and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract

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
Eligible Billed Charges
Requirements for Documentation of Proof of Timely Filing
EDI Claims Companion Guide for Professional Service