Reimbursement Policy

Subject: **Corrected Claims**	
Policy Number: **G-16001**	Policy Section: **Administration**
Last Approval Date: **08/28/2023**	Effective Date: **12/01/2022**

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

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Blue Cross and Blue Shield (Anthem) covered the service for the member's 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for a Corrected Claim when received within the applicable timely filing requirements of the original claim unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

The corrected claim must be received within 365 days from date of service.

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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.

Anthem 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	
08/28/2023	Review approved: updated Exhibit A; updated to 365 calendar days; added definition of Corrected Claim
12/01/2022	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • State Medicaid

Definitions	
Corrected Claim	The resubmission of an entire claim as a replacement, due to omitted charges or changed claim information.
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
Proof of Timely Filing

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