BlueCross BlueShield of North Carolina | HealthyBlue

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.healthybluenc.com**. ****

Disclaimer

These reimbursement 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 by a Healthy Blue 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, Blue Cross NC 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.
Blue Cross NC 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

Blue Cross NC 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. Blue Cross NC follows the standard of 180 days from date of service for participating and 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.

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

Blue Cross NC waives the corrected claims filing requirements for retroactive encounter denials.

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

07/23/2021	Biennial review approved and effective: Updated policy template
01/01/2021	Initial policy approved and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Department of Health and Human Services, DHB Contract

Definitions

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