	Reimbursement Policy	
Subject: Corrected Claims		
Effective Date: **05/24/19**	Committee Approval Obtained: **11/26/19**	Section: **Administration**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 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 non-contracting 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, Amerigroup Medicare Advantage may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Amerigroup 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 to this site.

Policy	Amerigroup 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, Amerigroup 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. Amerigroup 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.
History	• Review approved **11/26/19**: Corrected claims timely filing for participating providers reworded • Biennial review approved and effective **05/24/19**: Policy template updated • Review approved **06/01/18**: Policy template updated • Initial policy approved **07/14/16** and effective **05/15/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts

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	• Claims Timely Filing • Eligible Billed Charges • Requirements for Documentation of Proof of Timely Filing
Related Materials	• EDI Claims Companion Guide for Professional Services