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

***** The most current version of our 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/DC. *****

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 an enrollee's Amerigroup District of Columbia, Inc. benefit plan. The determination that a service, procedure, item, etc. is covered under an enrollee'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 enrollee's District 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 both participating and nonparticipating providers and facilities.

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

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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 strives to minimize these variations.

Amerigroup 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 allows reimbursement for a corrected claim when received within the applicable timely filing requirements of the original claim in compliance with federal and/or District 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. For participating and nonparticipating providers, Amerigroup follows the standard of 365 days from the date of the Remittance Advice.

	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, district-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 reserves the right to waive corrected claim filing requirements on a temporary basis following documented natural disasters or under applicable district 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**: Policy template updated • Biennial review approved and effective **05/24/19**: Policy template updated • Review approved **06/01/18**: Policy template updated • Initial policy approved **07/19/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance
Definitions	• **Frequency Code:** Indicates the claim is a correction of a previously submitted and adjudicated claim. Providers should use one of the following: o 1 — Original Claim o 7 — Replacement of Prior Claim o 8 — Void/Cancel Prior Claim • **Resubmission Period**: Refers to the initial claim timely filing requirements • **General Reimbursement Policy Definitions**
Related Policies	• Claims Timely Filing • Reimbursement for Eligible Billed Charges • Requirements for Documentation of Proof of Timely Filing
Related Materials	• EDI Claims Companion Guide for Professional Services