Reimbursement Policy:

Corrected Claim Submission

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20230037	1/01/2023	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview: A corrected claim replaces a previously submitted claim and includes a change in relevant information. Relevant information is information that could impact the way a claim is processed if that information were considered.

If a healthcare provider identifies that a previously submitted claim is incorrect or incomplete, a corrected claim with accurate information should be submitted by the steps outlined in this policy.

Policy Statement: The corrected claims process begins when you receive a notification of payment or explanation of payment from EmblemHealth/ConnectiCare detailing the claims processing results. A corrected claim should only be submitted for a claim that has already paid, was applied to the patient's deductible/copayment or was denied by the Plan, or for which you need to correct information on the original submission. *Note: Please allow 30-days for initial claim processing/EOP before submitting a corrected claim.*

Corrected Claim Guidelines:

Following the corrected claims guidelines below may reduce duplicate service denials and other unexpected processing results.

- When filing multiple-page paper claims:
  - Number pages (i.e., Page 1 of 3, Page 2 of 3, etc.)
  - Do not place the total charges for all services billed in the total charge field on each claim form. Only indicate the claim total charge on the last page.
- File all services for a particular date of service on the same claim form.

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- Do not mark claim "corrected" if additional information is requested, such as medical records or primary carrier EOB, unless a change is made to the original claim submission.
- Include ALL services to be considered for payment when submitting a corrected claim. This includes services that may have already paid on the original claim submission.
- When changing a member ID number or date of service for a processed claim:
    - Submit a corrected claim canceling charges for the original claim, AND
    - Submit a new claim with the correct member ID number or date of service.

- EmblemHealth/ConnectiCare allow reimbursement for a Corrected Claim when received within the applicable corrected claim timely filing requirements. Corrected Claims filed beyond the timely filing limit will be denied as outside the timely filing limit.

- EmblemHealth/ConnectiCare allow 100 additional days from EmblemHealth/ConnectiCare original claim submission timely filing limits for providers to submit a Corrected Claim.

    ***For example**: If timely filing is 120 days, providers have 220 days from the date of service to submit a corrected claim.*

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.

Corrected Claims Submission:

Electronic Format:

1. For corrected professional (837P) claims, in the 2300 Loop, the CLM segment (claim information), CLM*05-03 (claim frequency type code) must indicate one of the following qualifier codes:
    - "7" – **replacement** (replacement of prior claim)
    - "8" – **void** (void or cancel a prior claim)
2. For corrected institutional (837I) claims**,** use bill type frequency codes to indicate a correction was made to a previously submitted and adjudicated claim in the 2300 Loop, the CLM segment (claim information), CLM*05-03:
    - "0XX**7**" – **replacement** (replacement of prior claim)
    - "0XX**8**" – **void** (void or cancel a prior claim)
3. The 2300 LOOP, the REF*F8* segment (Claim Information), must include the original claim number issued to the claim being corrected. The original claim number can be found on the remittance advice.

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CMS-1500 (Professional) Paper Claims:

- On the CMS-1500 Form in Box 22, Corrected Claim Indicator
- Enter the frequency code "7" in the "Code" field and the original claim number in the "Original Ref No." field, ***OR***
- To void (void or cancel a prior claim), enter the frequency code "8" in the "Code" field and the original claim number in the "original Ref No." field

UB-04 (Facility) Paper Claims:

1. On the UB-04 (CMS 1450) Form, use Box 4 (Type of Bill):
   - Enter either "7" (corrected claim),
   - "5" (late charges), ***OR***
   - "8" (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill).
2. Then in box 64 (Document Control Number), enter the original claim number

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	4/25/2024	• Change to revision from 3/28/2024; corrected claim(s) filing limit updated with example provided for clarity.
EmblemHealth ConnectiCare	3/28/2024	• Updated to clarify timely filing limit of 100 days from the original claim adjudication date
EmblemHealth ConnectiCare	10/2023	• Updated Corrected Claim Guidelines to clarify that timely filing limits apply
EmblemHealth ConnectiCare	6/2023	• New Policy