Tennessee | Medicaid

Reimbursement Policy
Corrected Claims

Policy Number: **G-16001**
Policy Section: **Administration**
Last Approval Date: **10/6/2025**
Effective Date: **10/6/2025**

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://provider.wellpoint.com/tn.

Policy

The health plan 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 the timely filing limit due to the initial claim not being considered a clean claim. The health plan follows the standard of:

- 120 days from the last payment notification (Explanation of Payment/Remittance Advice) for participating providers and facilities.
- 120 days from the last payment notification (Explanation of Payment/Remittance Advice) for 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 the claim not being approved as a duplicate.

Medicaid coverage provided by Wellpoint Tennessee, Inc.
We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call **833-731-2154**. Information about the civil rights laws can be found at **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.
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Corrected claims filed beyond federal, state-mandated, or company standard timely filing limits will not be approved, as they are outside the timely filing limit. Services not approved 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.

The health plan reserves the right to waive corrected claim filing requirements on a temporary basis following documented natural disasters or in accordance with 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

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: 7 - Replacement of a Prior Claim or 8 - Void/Cancel of Prior Claim

Related Policies and Materials

- Claims Submission – Required Information for Facilities
- Claims Submission – Required Information for Professional Providers
- Claims Timely Filing
- Eligible Billed Charges
- Proof of Timely Filing

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- National Uniform Billing Committee (NUBC)
- State contract
- State Medicaid

Policy History

- **10/06/2025 -** Review approved and effective: updated Definition section
- **08/28/2023 -** Review approved: added definition of Corrected Claim
- **07/23/2021 -** Review approved: policy template updated
- **06/01/2018 -** Review approved: policy template updated
- **07/19/2017 -** Review approved: policy template updated
- **07/14/2016 -** Initial approval 07/14/2016 and effective 05/15/2017

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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

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