Corrected Claims

Reimbursement Policy ID: RPC.0122.DEDS

Recent review date: 02/2026

Next review date: 03/2027

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines AmeriHealth Caritas VIP Care reimbursement criteria for corrected claims submitted on forms CMS-1500 and CMS-1450 (UB-04) via EDI (Electronic Data Interchange) clearinghouse, Provider Portal, or paper format.

Exceptions

N/A

Reimbursement Guidelines

Providers should ensure that claim coding is accurate and that all required claim fields are completed when submitting claims to AmeriHealth Caritas VIP Care. Claims and/or claim lines that contain coding errors or invalid claim data elements may be denied by AmeriHealth Caritas VIP Care. Providers may elect to correct and resubmit denied claims for reprocessing via the NaviNet Provider Portal, EDI (Electronic Data Interchange) clearinghouse, or paper claim format. For processing purposes, corrected claims are treated as new claims by AmeriHealth Caritas VIP Care.

Common Reasons for Claim Corrections
Invalid, Missing, or Updated Modifier
Invalid, Missing, or Updated HCPCS/CPT/Revenue/NDC code(s)
Missing Claim Information (EOB, Consent Form, MSRP, Invoice, etc.)
Other changes (e.g., units, charges)

Corrected claims must reference the prior AmeriHealth Caritas VIP Care claim number and be appropriately coded to indicate whether they are intended to replace a prior claim (837I) or as a correction to a prior claim (837P). Corrected claims that do not meet these requirements will be denied.

Corrected Claim Requirements

- Paper claims should be submitted on standard, red-colored CMS-1500 or CMS-1450 (UB04) forms.
- Paper claims must not contain stamped or handwritten content.
- All claim corrections should include the original ICN (Internal control number).
    - Paper Claims - field 64 of CMS-1450(UB-04) or field 22 of CMS-1500.
    - Electronic submissions, select applicable 837 transaction loop.
- Include the appropriate frequency code/resubmission code in field 4 of form CMS-1450 (UB-04) and field 22 of form CMS-1500.

NOTE: Corrected claims are subject to AmeriHealth Caritas VIP Care timely filing limits based on the claim date of service.

Frequency and resubmission codes are published in the National Uniform Claim Committee (NUCC) manual for CMS-1500 claim forms and in the Uniform Billing Editor (UBE) for CMS-1450 (UB-04) claim forms to indicate a correction to a previously submitted and adjudicated claim.

- 1 — Original Claim
- 7 — Replacement of Prior Claim
- 8 — Void/Cancel Prior Claim

Resubmission of a previously denied claim <u>does not</u> constitute a claim adjustment or correction.

AmeriHealth Caritas VIP Care recognizes specific bill types for handling adjustments and reversals of previously paid claims:

Bill Type = xx8

Used to cancel an original paid claim in a single action, (i.e., Void/reverse payment on the original claim.)

Bill Type = xx7

Used to modify information on a previously paid claim in two steps:

1. Reverse the original claim, and
2. Replace information on the original claim with information on the corrected claim.

Bill type xx7 is used to modify any claim field **except**:

- Provider number error on an original paid claim.
- Member ID error on the original paid claim.
- Bill type error on the original paid claim.

Adjustment Claims Key Fields

Key fields for adjustment of electronic claims are as follows:

- CLM05-3: Frequency code (last digit) of the Bill Type.
- 2300 REF = F8: Original Reference Number, with REF01 = F8 and REF02 = Internal Control Number (ICN) (i.e., AmeriHealth Caritas VIP Care claim number from the original claim.)

Claim Field	Claim Form	Form Locator	Field Value
Type of Bill	CMS-1450 (UB04)	FL4	3rd Digit • 7 (Adjustment to a previous claim) • 8 (Void previously paid claim)
Document Control Number	CMS-1450 (UB04)	FL64	Previous AmeriHealth Caritas VIP Care Claim Number or Provider Control Number
Adjustment or Reversal	CMS-1500	FL22	This field is **only** used to adjust or void a previously paid claim. • 7 (Adjustment) • 8 (Reversals/Void)

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. AmeriHealth Caritas VIP Care provider manual.
VII. Applicable Delaware Medicaid Fee Schedule(s)

Attachments

N/A

Associated Policies

RPC.0016.0000 Submission of Claims

Policy History

02/2026	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section