PCHP Reimbursement Policy		
Topic: Corrected Claims	Policy Number: PCHP.RI.001	Policy Section: Administration
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

PCHP allows reimbursement for corrected claims submitted within 120-days from the last payment notification (EOP/RA) in accordance with Texas applicable timely filing requirements.

Providers submitting paper claims for corrections must clearly indicate "Corrected Claim" on the claim form. Corrected claims submitted electronically must include the appropriate frequency code. Failure to properly mark the claim may result in denial as a duplicate.

Corrected claims submitted beyond the 120-day timely filing limit will be denied as outside the filing limit. Services denied for failing to meet timely filing requirements will not be eligible for reimbursement unless the provider can provide documentation proving that a corrected claim was filed within the applicable filing limit.

Corrected claims must be submitted individually for each member and episode of care and cannot be included in batch, bulk, or packaged submissions.

PCHP reserves the right to temporarily waive corrected claim filing requirements in cases of documented natural disasters or under applicable state guidance.

References:

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative, National Uniform Billing Committee (NUBC)

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025