MASSACHUSETTS

CLAIM RESUBMISSION GUIDE

How to submit electronic claim resubmission requests using frequency code 7 or 8

INTRODUCTION

Please submit resubmission claim requests using electronic data interchange (EDI) 837 transactions.

IMPORTANT: You must already be approved to submit 837 transactions to Blue Cross Blue Shield of Massachusetts. There are also restrictions on the types of changes you can request to the original claim using this method.

To access the ***Blue Book*** office manual mentioned in this guide, log in to **bluecrossma.com/provider** and go to **Office Resources>Policies & Guidelines>Provider Manuals**. Then click on the document, *Reviews & Appeals*.

TO SUBMIT WITH FREQUENCY CODE 7 (REPLACEMENT CLAIM)

Your submission:

- Must contain corrected information for an original claim.
- Must serve as a full replacement of that claim (a 1:1 request). You cannot submit one replacement claim for multiple original claims.
- Must represent the entire new claim—not just the line or item that you are changing.
- Must ***not*** include an appeal request (Request for Claim Review Form).
- Can include changes to the original claim, plus new charges for services not previously submitted. However, it must meet the timely filing guidelines outlined in the *Blue Book* manual.
- Can be used for late charges for Medicare Advantage claims only and must be used according to Section 110, Chapter 4 of the CMS Claims Processing Manual.
- Requires the following three fields:

REQUIRED FIELD	YOU MUST SUBMIT
Claim frequency code	• Go to Claim segment field CLM05-3 • Value 7 replacement requests • Value 8 full void/retraction requests
Claim note	NTE segment, with qualifier UPI for 837I and qualifier ADD for 837P and the narrative or claim change reason code that explains why the resubmission or void request is being submitted. Examples include: • “Updated procedure code” • “Changed diagnosis code” • “Full void because of service not rendered”
Original reference number	REF02 segment, use qualifier value F8. Provide the original claim number to be referenced. This is the claim number that Blue Cross assigned to your original submission.

FREQUENCY CODE 7 EXAMPLES

In most cases, a data change is required to use frequency code 7.

Use frequency code 7 to:

- Correct the date of service (the original date(s) of service must fall within the new date span on your replacement claim).
- Correct patient data (except the subscriber ID; please submit a new day claim with claim frequency = 1 (CLM05-3).
- Correct the diagnosis, procedure, or modifiers.
- Correct other insurance dollars, including removing all other insurance information.
- Add service lines *in addition to* data correction(s) to original claim**.** (If only adding late charges, please see separate instructions for the use of a frequency code 5).

You can use frequency code 7 without a data change ***only*** when:

- A claim previously rejected for "no authorization on file," and an authorization is now on file.
- Eligibility has been updated.

DO NOT USE FREQUENCY CODE 7….

- When a claim is rejected for Taxonomy/NPI and or Tax ID combinations. In this situation, correct the information and submit a new claim.
- When appealing or questioning pricing, benefits, or membership coverage dates on a claim. Follow the appeal guidelines noted in the *Blue Book*.
- On claims that we denied because they did not meet our timely filing guidelines. Our Provider Services Department manages timely filing appeals. For these claims, follow the instructions in the *Blue Book*.
- For claims originally denied because necessary attachments were not included, or for services that require additional documentation for review. Please follow the appeals process outlined in the *Blue Book* to submit the required information.
- When submitting only late charges. Please refer to the billing guide for frequency code 5. **Note: You cannot use frequency code 5 for Medicare Advantage claims**.
- To change the type of bill from outpatient to inpatient, or from inpatient to outpatient on a professional or facility claim. **Note: To change the level of care, you must first void your original claim with frequency code 8. Once the void has finalized, then submit a new claim (no frequency code) with the accurate level of care**.
- To make changes to "bridged admission" facility claims. Follow appeal guidelines in the *Blue Book*.
- For claims that rejected on the EDI front end. You must resubmit this type of claim as a new-day claim, with claim frequency = 1 (CLM05-3).
- For a previously recovered claim.

TO SUBMIT WITH FREQUENCY CODE 8 (FULL VOID OR RETRACTION)

Frequency code 8:

- Must be used to fully void a claim.
- Must represent the entire claim—not just the line or item that you are retracting.
- Must serve as a full void of the claim (a 1:1 request). You cannot submit one resubmission claim for multiple original claims.

FREQUENCY CODE 8 EXAMPLE

- Use frequency 8 when submitting for a fully voided claim. EDI requests require two fields at the loop 2300 level to be coded to process through the Blue Cross claims adjudication system.
  - Claim segment, field CLM05-3
  - Value 8 indicates “Voided”
  - REF 02—Use qualifier value F8-Provide original claim number to be referenced.
- For example: It must represent the entire claim and serve as a full void of the claim, not just the line or item that you are retracting. You cannot submit one resubmission claim for multiple original claims.

DO NOT USE FREQUENCY CODE 8….

- On totally denied claims.
- To make changes or corrections to an original claim.
- To add late charges to an original claim.

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