Requirement to submit a replacement claim for denied claims

Frequently Asked Questions

Current as of October 1, 2018

Here are some answers to frequently asked questions about submitting a replacement claim when your original claim has fully denied.

General questions

What is the difference between a fully denied and a partially denied claim?

A fully denied claim is one in which all service lines are denied and will not pay. A partially denied claim is one in which some service lines pay and others are denied.

Should we submit a replacement claim to make a correction to a partially denied claim (a claim in which some service lines of the claim pay, but not all)?

Yes, effective July 1, 2018, you should submit replacement claims for partially denied claims. Please follow the current process for a fully denied claim at that time. If you are already following this process for partially submitted claims, you do not need to wait until July 1.

If the level of care changes from inpatient to outpatient after we've submitted the original claim, what do we do?

You will need to request a retraction and submit a new day claim. You cannot submit a replacement claim using frequency code 7 for this type of change, as noted in our Replacement Claim Frequency Code 7 Request Guide.

Which claims need a replacement claim?

You need to submit a replacement for a claim that is either fully or partially denied when you need to:

- Review previously submitted diagnosis codes, procedure codes, or modifiers
- Correct patient data, except for the member ID
- Change the billed amount on the original claim
- Correct a claim that denied for a referral or authorization if one has since been approved.

We offer more details in our Replacement Claim Request (Frequency Code 7) Guide, so please be sure to review this Guide and share with your billing and IT departments.

Can we send a replacement claim for a "bridged admission" claim?

No, please do not submit a replacement claim for a bridged admission claim. Follow the appeal guidelines listed in the Reviews & Appeals section of the *Blue Book* provider manual.

What claims don't qualify for a replacement claim submission?

Please do not submit replacement claims when you want to:

- Appeal a claim – please follow the appeal guidelines noted in the Blue Book office manual
- Submit claims that denied for timely filing
- Change the billing NPI
- Correct the subscriber ID
- Make changes to bridged claims
- Change the dates of service if the revised dates fall outside of the date span of the original claim
- Change the level of care from inpatient to outpatient, and vice versa

Will we still be able to call or submit a written appeal for an underpayment?

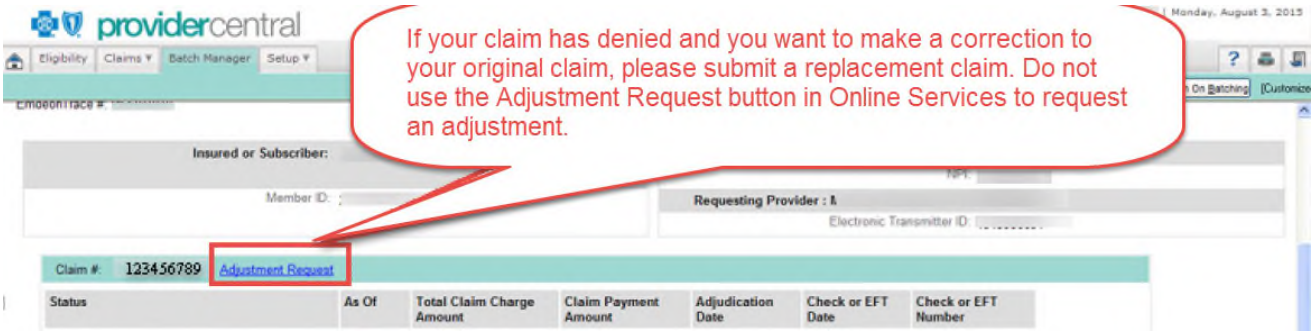
As noted in our Replacement Claim Frequency Code 7 Request Guide, when appealing or questioning pricing, you should follow the appeal guidelines listed in the Reviews & Appeals section of the *Blue Book* provider manual.

What should we do if we think Blue Cross incorrectly denied a claim in full?

If you believe all the information on your claim is correct, you can call us for an explanation or send us a written inquiry, and we'll reply to you. You should submit a replacement claim when you are requesting an adjustment to a *fully denied* or *partially denied* claim.

If we want to make a correction to our original billing, can we use the Adjustment Request button in Online Services to request an adjustment to a fully or partially denied claim?

No, if your original claim fully or partially denies *and* you want to make a correction to the original billing, you **must** submit a replacement claim. **Do not** use the "Adjustment Request" button in Online Services to request an adjustment (see example below).



My claim denied for no referral or authorization. Can I ask you to adjust the claim?

We will help with phone or written inquiries when the member has an authorization or referral from a primary care provider (PCP) outside of Massachusetts. Otherwise, if you've verified that your referral or authorization is on file with us and has been updated to match your claims, you should submit a replacement claim.

Can I submit a replacement claim to change the subscriber's ID?

No, do not submit a replacement claim to change the subscriber ID. You'll need to submit a new day claim with claim frequency = 1 (CLM05-3) as noted in our Replacement Claim Frequency Code 7 Request Guide.

My claim denied saying the specialty cannot perform these services. Should I submit a replacement claim?

No, a replacement claim would not correct this denial. You should follow the appeals process.

Can I submit a replacement claim for a claim that previously rejected because it was over the timely filing limit?

You should ***not*** submit a replacement claim if:

- The original claim processed more than one year ago and now you want to adjust it. Our policy is that adjustment requests must be submitted within one year of the date the claim processed.

- The original claim rejected because it was submitted over the timely filing limit.

For an adjustment request, please follow our standard appeals process:

- Submit the Request for Claim Review Form. Make sure to:
  - Include the denial code
  - Check off that your claim request is for the "Filing Limit," and
  - Include any documentation to support your appeal (refer to our *Blue Book* provider manual for details).

  Send this form to us at:

  PO Box 986065
  Boston, MA 02298-6065
- Call Provider Service
- Use the Adjustment request button in Online Services. **Important:** Don't use this button if you need to include attachments to support your appeal.

Note: You have one year from the date the claim processed to request an adjustment.

Replacement claim submission questions

Should we include the internal control number (ICN) of the original claim on the replacement claim?

Yes, you must include the ICN.

- For electronic claims, enter the ICN into REF02 with qualifier = F8
- For paper 1500 claims, enter the ICN in Item 22, Original Ref No.
  (You should *not* include a note on the paper claim form to tell us what you are changing about the claim.)

When submitting a second replacement claim, which internal control number (ICN) should we include?

Always enter the most recent ICN on the claim. Include the 12-digit base claim number, followed by the two-digit code, for example, 201612345678**02**.

- For electronic claims, enter the ICN into REF02 with qualifier = F8.
- For paper 1500 claims, enter the ICN in Item 22, Original Ref No.

If we change the billing provider, would this be considered a replacement claim?

No, you should not submit a replacement claim to change the billing provider information. You will need to request a retraction and submit a new day claim.

What should we do if we have a multi-line claim that needs an administrative change to one line, and to appeal the denial message on another line?

You should follow the appeal process. The documents submitted to appeal will be reviewed, AND the administrative changes requested will be made.

Can you show me a sample replacement claim showing the information we'll need to submit?

For ANSI-837P (Professional claims)
Both items listed below must be completed to consider the claim a corrected claim.

1. In the 2300 Loop, the CLM segment (Claim Information) CML05-03 (Claim Frequency Type Code) must indicate one of the following qualifier codes:
    - "7" – Replacement (replacement of prior claim)

2. In the 2300 Loop, the REF02 segment (Original Reference Number [ICN/DCN]) must include the original claim number issued to the claim being corrected. You can find the original claim number on your Provider Payment Advisory.

For ANSI-837I (Institutional)
Both items listed below must be submitted on an ANSI-837 to be considered a corrected claim.

1. In the 2300 Loop, the CLM segment (Claim Information) CML05-03 (Claim Frequency Type Code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an adjustment, a replacement, or a voided claim:
    - "7" – Replacement (replacement of prior claim)

2. In the 2300 Loop, the REF02 segment (Original Reference Number [ICN/DCN]) must include the original claim number issued to the claim being corrected. You can find the original claim number on your Provider Payment Advisory.

For paper claims

1. On the 1500 claim form, in Item 22 Resubmission Code, enter a 7. Include the previously submitted claim number in the Original Ref. No. block.

2. On the UB-04 claim form, in the Type of Bill field (Form locator 04), enter a frequency code of 7.

If it's an electronic claim, do you need the REF*F8 segment in loop 2300?

Yes, for electronic claims we need the REF*F8. Please refer to pages 51 and 52 of our 837 Companion Guide.

What are the guidelines on using frequency 7 versus using frequency 5?

Frequency 5 is typically used *only* to submit late charge claim requests. To get more details on using frequency 7 and frequency 5, please share these billing guidelines with your Information Technology or billing department:

- How to submit EDI HIPAA late charge claim requests (claim frequency code 5) using 837 institutional and professional transactions <link>
- How to submit EDI HIPAA replacement claim requests (claim frequency code 7) using 837 institutional and professional transactions <link>

Can we submit our replacement claim electronically using the Online Services Direct Data Entry tool?

If you bill on a 1500 claim form, you can submit a replacement claim using the Direct Data Entry tool in Online Services. For details, review our *Direct Data Entry Set-up and User Guide* (go to the correcting a fully denied claim section). You'll find this Guide by logging on to **bluecrossma.com/provider** and going to **eTools>Online Services**. Scroll down to the resources section.

Replacement claim status questions

How do I check the status of a submitted replacement claim?

To check the status of your replacement claims, use the same process you use for checking the status of all your claims.

I submitted a replacement to a denied claim for a BlueCard member (a member of another Blue Cross plan). I didn't get a Provider Detail Advisory yet showing the claim has processed. Why?

First, please use technologies to check the status of your claim. Then, if you don't get a Provider Detail Advisory within our typical claims processing timeline, you can call Provider Service.
If the member's plan denies the replacement claim due to their eligibility or because they have another insurance, we will send you a letter explaining why your replacement claim could not process.

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