MASSACHUSETTS

REPLACEMENT CLAIMS

Frequently asked questions

Replacement claims are used to **correct** information previously submitted on a 1500 or UB-04 claim.

Important notes

- Unless your claim requires a copy of another insurer's Explanation of Benefits or Payment, do ***not*** include additional documentation with your replacement claim.
  - More information about submitting Coordination of Benefits claims is available on Provider Central.
- Do ***not*** submit a replacement claim to appeal a denied claim. If your claim has an error, send the replacement claim first. When we issue an updated Provider Detail Advisory, you can appeal the denial by sending a completed Request for Claim Review Form to Provider Appeals.

Exceptions

You cannot use replacement claims to:

1. Change or correct the:
   - Billing NPI
   - Date of service (when it falls outside the original date span)
   - Level of care (inpatient to outpatient, or vice versa)
   - Subscriber ID

2. Submit for **timely filing** review

3. Correct a **bridged admission** claim

4. Submit claims related to **accidental injuries** (auto or workers' compensation)

5. Correct a claim that was part of a previous **recovery.**
   Examples:
   - Credit balance
   - Provider audit
   - Claims recovery project

See our Claim Resubmission Guide (Frequency Codes 7 & 8) and the Blue Book for more information. To access the Blue Book, log in to **bluecrossma.com/provider** and go to **Office Resources>Policies and Guidelines>Provider Manuals**.

Use the links below to go to a specific topic:

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Submitting replacement claims

Q: How do I submit a replacement claim with corrected information?

A:

For	Use these guidelines
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.
ANSI-837I (facility claims)	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.
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. Reminders:

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Do not include a cover sheet or any additional documentation.
Make sure you use the correct claims address below.

<table>
<tr><th>1500 claims to</th><th>UB-04 claims to</th></tr>
<tr><td>Blue Cross Blue Shield
Data Capture
PO Box 986020
Boston, MA 02298</td><td>Blue Cross Blue Shield
Data Capture
PO Box 986015
Boston, MA 02298</td></tr>
</table>
If you send a replacement claim to the appeals address, it will not be processed. We will you advise you as such by letter.
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Q: Should I include the internal control number (ICN) of the original claim on the replacement claim?

A: Yes, you must include the most recent 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. (Do *not* include a note on the paper claim form to tell us what you are changing about the claim.)

Q: How do I handle claims when another insurance is primary and I have the primary EOB?

A: If, after we have processed the claim, the primary insurer increases or decreases payment, submit a paper replacement claim and attach the EOB with the new information.

Q: If the claim is over two years old and needs to be retracted, should a replacement claim be submitted?

A: Yes, submit it with frequency code 8 for full voids/retractions.

Q: How can I add dates of service or charges to a claim?

A: Add the dates of service to the original claim leaving the information already on the claim. Do not resubmit a new claim with all the new charges.

Q: How can I remove a single line on a claim?

A: Submit the replacement claim leaving off the information you no longer want on the claim.

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Claim status

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

A: You should use the same process you use for checking the status of all your claims.

Q: I submitted a replacement to a denied claim for a BlueCard* member and didn't get a Provider Detail Advisory yet. Why?

A: After you've used technologies to check the status of your claim, 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.

*BlueCard means a member of an out-of-state Blue Cross Blue Shield plan.

Claims that don't qualify as replacements

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

A: No. Do not submit a replacement claim to change the subscriber ID. You'll need to submit a new claim as noted in our Claims Resubmission Guide.

Q: Can I submit a replacement claim to appeal a denied claim?

A: No. Follow the appeal guidelines in the Blue Book office manual. Log in to Provider Central at bluecrossma.com and go to Office Resources>Policies and Guidelines>Provider Manuals>Facilities & Professionals>Reviews & Appeals.

Q: If I change the billing provider, is this considered a replacement claim?

A: No. You should not submit a replacement claim to change the billing provider information. You will need to request a retraction/full void using frequency code 8 and submit a new claim.

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

A: No. You should follow the appeals process. A replacement claim is for when you need to make changes to the original billing.

Q: Can I send a replacement claim for a "bridged admission" claim?

A: No. Follow the appeal guidelines listed in the Reviews & Appeals section of the *Blue Book* provider manual.

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Q: Can I use a replacement claim for services related to an injury involving an auto accident or Workers' Compensation?

A: No. Send your paper claim, with related documentation attached, to the appropriate PO box.

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

A: No. Please do ***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.

To appeal a timely filing rejection, please follow our standard appeals process:

- Fill out 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 (see our *Blue Book* provider manual for details).

Send this form and supporting documentation to us at:
Provider Appeals
PO Box 986065
Boston, MA 02298-6065

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

Q: On a multi-line claim, what should I do if I have an administrative change on one line, and want to appeal the denial message on another line?

A: Follow the appeal process. We will review the documents submitted and also make the administrative changes requested.

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

A: You will need to request a full void/retraction with frequency code 8 and submit a new claim. You cannot submit a replacement claim using frequency code 7 for this type of change, as noted in our Claim Resubmission Guide.

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Electronic claims

Q: Do you need the REF*F8 segment in loop 2300 for electronic claims?

A: Yes, for electronic claims we need the REF*F8. Please see section 10.4 of our 837 Companion Guide.

Q: Can I submit our replacement claim electronically using the ConnectCenter?

A: Yes, you can submit a replacement claim using ConnectCenter. Copy the claim that denied, make the correction, and in Box 22 (Resubmission Code), select **Replacement Claim**. Enter the original Blue Cross claim number in the **Original Reference Number** field. For more about Direct Data Entry in ConnectCenter, review our *ConnectCenter Claims Quick Tlp*. You'll find this resource by logging on to **bluecrossma.com/provider** and going to **eTools>ConnectCenter**.

Frequency codes

Different frequency codes are used for different situations. You must include the appropriate frequency code on all replacement claims.

Frequency code	Use for
5	Late charge submissions (adding charges not billed on original submission).
7	Replacement claims where you are correcting or changing information
8	When you want to fully voids or retract a claim. • Use for claims denied for timely filing. • Do not use for totally denied claims.

Q: When should I use frequency 7 versus using frequency 5?

A: Use frequency 7 to make changes to previously submitted information. Frequency 5 should be used to submit **late charge**s. For more details, see:

- How to submit EDI HIPAA late charge claim requests (claim frequency code 5) using 837 institutional transactions
- How to submit electronic claim resubmission requests using frequency code 7 or 8

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Contacting Blue Cross

Q: What should I do if I think Blue Cross processed a claim incorrectly?

A: If you believe all the information on your claim is correct, you can call us for an explanation or send us a written appeal. If you need to make changes, submit a replacement claim.

Q: What will happen if I call or send a written inquiry on a claim that requires a replacement claim?

A: The adjustment will **not** be completed over the phone or through a written inquiry.

- If you call, we will direct you to the replacement claim process.
- If you write, we will send a letter advising you to follow the replacement claim process.

Q: My claim denied for no referral or authorization. Can you adjust the claim?

A:

- If a patient's referral or authorization is from their *out-of-state primary care provider*, we can help you via phone or written.
- For other patients, if you've verified that your referral or authorization is on file with us and has been updated to match your claims, submit a replacement claim.

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