Quick Points

November 4, 2009

Information on submitting appeals, replacement claims and void/cancel claims

The Administrative Simplification changes that were effective July 15, 2009, have generated significant inquiries related to submission of replacement claims, void/cancel claims and appeals. This document is intended to answer some of the common questions related to proper submission requirements. Please note that section A contains general information, and section B is for specific handling of coordination of benefits (COB) related scenarios.

Section A- general information

1. **What is an example of a replacement claim? I have read the Administrative Uniformity Committee (AUC) description and would like some clarity on these claims.**
   A replacement claim, to paraphrase the Minnesota Uniform Companion Guides for claims, is used to completely replace a previously submitted claim when data within the claim record is added, changed or deleted. An example would be a professional claim sent with all diagnosis pointers set to "1." On review by the provider after original payment, it is determined the second procedure was done in reference to the third diagnosis on the claim. A replacement claim is sent to correct the diagnosis pointer on line 2.

   See section 4.2.3.2 of the Minnesota Uniform Companion Guides, version 4.0, dated March 2009, and the related AUC *Replacement/Void Claims* Best Practice available on the AUC website at **www.health.state.mn.us/auc.**

2. **Can I send a replacement claim if I have the wrong subscriber ID on the previous submission?**
   No. According to the AUC *Replacement/Void Claims* Best Practice, "When identifying elements change, a void submission is required to eliminate the previously submitted claim." Changes to identifying information related to the billing provider, patient, payer, subscriber or statement covers period dates, require that a Void Claim transaction be submitted for the original claim and that a new claim with the corrected information be submitted to the payer. These requirements are similar to the Centers for Medicare & Medicaid Services (CMS) requirements.

3. **Can I send an attachment on a replacement claim?**
   Yes, if it is relevant to the changes being made on the replacement claim or needed to support a particular coding change. For example, the addition of a -59 modifier to indicate that the service being billed is a distinct procedure or service will require supporting medical documentation to be submitted with the replacement claim.

4. **If Blue Cross and Blue Shield of Minnesota denied my claim because the date of injury was required but not submitted in the claim, can I send an AUC Appeal Request Form to have the claim reconsidered and list the requested Date of Injury in the Reason for Appeal section?**
   No. You must submit a replacement claim with the corrected data (injury date) in the 837 transaction.

5. **What is an appeal?**
   The Minnesota Uniform Companion Guides, version 4.0, dated March 2009, section 4.2.3.2, describe an appeal as "Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional

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or corrected data to be submitted." [1] For example, you receive a claim denial because we considered the procedure investigative. Your request to reconsider must be submitted on the AUC Appeal Request Form along with supporting documentation following the instructions in the AUC *Submission of Appeals* Best Practice. Fax the AUC Appeal Request Form and supporting documentation to Blue Cross at **(651) 662-2745.**

6. **What are some examples of reasons for appeals?**
   The following is a list of reasons to send an appeal, according to the Minnesota Uniform Companion Guide(s) for Claims:

   • timely filing denial
   • payer allowance
   • incorrect benefit applied
   • eligibility issues
   • benefit accumulation errors
   • medical policy/medical necessity

7. **All of the claim information was submitted correctly; however, it appears not all claim data I sent was recognized by the system. Is it acceptable for me to call Blue Cross to simply have my claim adjusted using what was previously submitted or do I need to appeal?**
   It is acceptable for you to request the claim be adjusted to recognize the data within the submission through a phone call to provider service. It would also be acceptable for you to submit your request using the AUC Appeal Request Form.

8. **I am sending documentation in response to a request for additional documentation from Blue Cross. Do I need to send a replacement claim with the attached medical records?**
   If you are responding to an information request letter sent by Blue Cross, regardless of whether you have also received a denial on your remittance, you should submit the requested information, along with a copy of the information request letter. Do not send an AUC Appeal Request Form. These same instructions are included on the letter that you receive.

9. **I am sending documentation in response to a denial on my remittance advice from Blue Cross. Do I need to send a replacement claim with the supporting information needed?**
   If you are sending the additional documentation as a result of a denial on a remittance advice only, and not in response to an information request letter from Blue Cross, and the claim requires changes to claim data elements (such as date of injury, procedure code changes, diagnosis code changes, etc.), then a replacement claim must be sent which includes any necessary attachments.

   If you are sending the additional documentation as a result of a denial on a remittance advice only and the claim **does not** require changes to claim data elements you also may send a replacement claim.

   If you are sending additional documentation because you believe you did not receive correct payment and this documentation supports your position, you must send the AUC Appeal Request Form along with the documentation to support your request.

10. **My billing system still cannot send claims in the 837 format as the AUC requires, so I can't send replacement claims at this time. Will Blue Cross still accept adjustments submitted the traditional way?**
    While we encourage providers to adopt the AUC changes as quickly as possible, we understand some may not be ready at this point. We are still accepting adjustment requests in the traditional way; however, at some point in the future, this option will be discontinued.

[1] Minnesota Uniform Companion Guide - Appeals

Section B – COB related scenarios

How do I send COB information when it was not included with the previous submission?

Scenario 1
If you have received a HIPAA compliant remittance advice (835), and your system has the capability to populate the information within a secondary claim, or the submission date is after December 15, 2009, you must submit a replacement claim with the data appropriately entered within the claim record.

Scenario 2
If you have received a HIPAA compliant remittance advice (835) from a prior payer and your system is not capable of populating the information within the HIPAA secondary claim transaction (837) before December 15, 2009, you may send a replacement claim with the addition of the PWK segment and send the paper remittance advice from the previous payer as an attachment.

Scenario 3
If you have not received a HIPAA compliant remittance advice (835) from the previous payer, you may send a replacement claim transaction with the addition of the PWK segment and send the paper remittance advice from the previous payer as an attachment.

NOTE: After December 15, 2009, all Minnesota Group Purchasers must provide a HIPAA and State of Minnesota compliant remittance advice, and providers are required by the Minnesota Uniform Companion Guides (section 4.2.3.5) to submit the previous payment information electronically using the proper fields within the claim transactions.

Questions?

If you have questions, please contact provider service at **(651) 662-5200** or **1-800-262-0820**.