Electronic Claim Adjustments
User Guide

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BlueCross BlueShield of Arizona

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Contents

Introduction

BCBSAZ accepts the HIPAA 837 transaction sets* for electronic professional (837P), institutional (837I), and dental (837D) claim adjustments. This user guide includes information on processes and HIPAA data requirements necessary for electronically submitted claim adjustments.

The *HIPAA Transaction Standard - BCBSAZ Companion Guide* also includes electronic claim adjustment information unique to BCBSAZ. Providers can access the companion guide on azblue.com/providers under "Electronic Business."

*HIPAA 837 transactions sets are used to electronically submit healthcare claim billing information or encounter information from healthcare providers to health plans or payers either directly or via intermediary billers or claims clearinghouses.

Request for reconsideration or adjustment of adjudicated claims

The 837 electronic claim adjustment request process follows the guidelines stated in the BCBSAZ Provider Operating Guide, Section 16, "Claim Submission" under "Claim Adjustments." These include:

- For claims that were submitted electronically, changes should be submitted via 837 adjustment requests. Paper claim corrections will be returned except when the original claim was submitted on paper or the correction is for a provider NPI change.

- Adjusting a provider NPI requires medical record documentation to verify the rendering provider. For this type of correction, use BCBSAZ's corrected claim form PDF and include the supporting documentation.

- When submitting an adjustment, include all line items from the original claim so that the adjusted claim is complete and can be compared line by line to the original. The adjustment will be returned if the claim information is incomplete.

- Providers are responsible for the completeness and accuracy of submitted claims. BCBSAZ may refuse to accept an adjustment if the provider has submitted multiple adjustments of the same claim.

- Most claim adjustments must be made within one year from the date the claim was originally processed. See the Provider Operating Guide, page 16-3 for exceptions to the one-year rule.

- Claim adjustments may only be submitted *after* the claim has finalized and the remit is available because BCBSAZ can't make corrections until after the claim is fully adjudicated. Any adjustments sent prior to that will be rejected.

- Medical records may be requested later to support certain corrections, but do *not* send them with the initial adjustment submission.

837 electronic claim adjustment reasons

For claims that were submitted electronically, submit any subsequent changes via an 837 adjustment request. Do *not* send medical records with the initial submission. Types of claim information corrections include (not an all-inclusive list):

- Patient name
- Place of service
- Date of service
- Billed charges
- Adding and/or changing modifiers
- Member ID
- Number of units
- Changing the sequence of diagnosis codes
- Late charges to inpatient or outpatient claims
- Other billing
- Anesthesia time
- Other insurance carrier COB payment

Note: Adjusting a provider NPI requires medical record documentation to verify the rendering provider. For this type of correction, use BCBSAZ's corrected claim form PDF and attach the documentation.

Appeals and grievance procedures

No claim corrections are permitted once a grievance or appeal has been filed. Nor will BCBSAZ accept an appeal and grievance request submitted via an 837 adjustment request. BCBSAZ will **_return_** this type of 837 adjustment request. For more information about member appeals and provider grievances, see the Provider Operating Guide, Sections 21 and 22.

Frequently asked questions (FAQs) to help you set up your systems

The following FAQs guide you to understand the electronic 837 adjustment request process and data element requirements.

Q1. *How are electronic adjustments sent/submitted?*
A1. The provider follows the same process used to submit electronic claims.

Q2. *Can I submit my daily electronic claims with my electronic adjustment requests in the same file?*
A2. Yes.

Q3. *If I have questions about the submission of electronic claims, who should I contact?*
A3. For information on electronic claim transactions, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

Q4. *What kind of adjustments can I send?*
A4. Providers can submit any adjustments as outlined below. Lines of business (LOBs) and claim types (type of bill) are:

Included

- BCBSAZ-insured members   Professional, institutional, and dental
- FEP members   Professional, institutional, and dental
- BlueCard (out-of-area) members   Professional and institutional
- CHS group members   Professional, institutional, and dental

Excluded

- BlueCard (out-of-area) members   Dental

Q5. *How do I indicate the electronic claim is an adjustment?*
A5. The provider indicates the following:

Type of bill for institutional claims
The 3rd position of the type of bill (values 7 or 8) indicates the claim is an adjustment.

Facility type code (place of service) for professional and dental claims
The 3rd position of the facility type code (values 7 or 8) indicates the claim is an adjustment.

Q6. *How do I communicate what I want to have adjusted?*
A6. BCBSAZ requires that all line-item information be submitted on the claim adjustment so that it can be compared to the original. In addition, the following information be must submitted in the electronic 837 adjustment request:
- Frequency code
  - Use frequency codes 7 or 8 to indicate that the claim is an adjustment.
- Original reference number
  - Include the claim number reported on the remittance advice you received concerning the previous adjudication.

Q7. *Are eAdjustment conditions codes required?*

A7. No, eAdjustment conditions codes are not required, but if you do submit them, refer to the following list for the values that BCBSAZ will accept:

D0	*Changes to service date (statement dates)*
D1	*Changes to charges*
D2	*Changes in revenue codes/HCPCS/HIPPS Rate Codes*
D3	*Second or subsequent interim PPS bill*
D4	*Change in clinical codes (ICD) for diagnosis and/or procedure codes*
D7	*Changes to make Medicare the secondary payer*
D8	*Changes to make Medicare the primary payer*
D9	*Any other change (including changes to service level dates)*
E0	*Change in patient status*

Q8. *What elements will be affected in my billing system and what do I tell my vendor regarding any required changes?*

A8. The portion of the *HIPAA Transaction Standard - BCBSAZ Companion Guide* for elements required on an 837 adjustment request (professional, institutional, and dental) can also be found below on pages 5 – 6. Please use these requirements when working with your vendor to make necessary changes to your billing systems.

Q9. *How will I know the adjustment was received by BCBSAZ?*

A9. Your Custom Claim Acknowledgement Report (CCAR)* contains a record of all received claims including adjustments.

* A "CCAR" is a "human-readable" report that contains information on all claims within a batch and includes a detailed status of rejected and accepted claims. For more information, see the *HIPAA Transaction Standard – BCBSAZ Companion Guide.*

Q10. *Does the Medicare cross-over process include adjustments?*

A10. Yes. The Medicare contractor will send adjusted 837s to BCBSAZ for BCBSAZ and senior product lines of business (excludes FEP).

Q11. *How should I submit Medicare cross-over adjustments?*

A11. Adjustments to claims that indicate Medicare is primary **must** be sent directly to Medicare. The adjustment, once processed by Medicare, will be electronically crossed over to BCBSAZ (excludes FEP). The provider **must not** send these adjustments directly to BCBSAZ.

Q12. *Can I submit claim adjustment requests on paper?*

A12. **Only** use BCBSAZ's corrected claim form PDF if you are unable to submit an 837 adjustment request, or if you are correcting a provider NPI number*. All other paper corrections will be returned.
  * To correct an NPI, you must include medical record documentation verifying the rendering provider.

Required loops and data elements

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by professional, institutional and dental, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be returned to the submitter/provider.

Use frequency code 7 to indicate that you are making adjustments to replace a prior claim. Use frequency code 8 when you want to void or cancel the original claim and start over with a new clean claim. BCBSAZ will return all 837 adjustment requests that do not include a frequency code 7 or 8.

837 PROFESSIONAL – Data elements for adjustments

ASC X12N/005010X222 A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3						
TR3 Page #	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/Comments**
159	2300	CLM05 - 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required:** Frequency code must be equal to **7** (replacement of prior claim) or: **8** (void/cancel of prior claim)
196		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	**Required:** Insert "F8"
196		REF02 Claim Information	Reference Identification	AN	1/30	**Required:** For **Local & FEP**, ICN/DCN must be 15 numeric characters. For **BlueCard**, ICN/DCN must be 15-17 numeric characters

837 INSTITUTIONAL – Data elements for adjustments

ASC X12N/005010X222 A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3						
TR3 Page #	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/Comments**
145	2300	CLM05 - 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required:** Frequency code must be equal to **7** (replacement of prior claim) or: **8** (void/cancel of prior claim)
166		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	**Required:** Insert "F8"
166		REF02 Claim Information	Reference Identification	AN	1/30	**Required:** For **Local & FEP**, ICN/DCN must be 15 numeric characters. For **BlueCard**, ICN/DCN must be 15-17 numeric characters.

837 DENTAL – Data elements for adjustments

ASC_X12N/005010X222_A1/E1						
ASC X12 Standards for Electronic Data Interchange Technical Report Type 3						
TR3 Page #	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/Comments**
147	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	**Required:** Frequency code must be equal to **7** (replacement of prior claim) or: **8** (void/cancel of prior claim)
168		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	**Required:** Insert "F8"
168		REF02 Claim Information	Reference Identification	AN	1/30	**Required:** For **Local & FEP**, ICN/DCN must be 15 numeric characters.