



CORRECTED CLAIMS, INQUIRIES AND APPEALS

THE CENTER FOR PROVIDER EDUCATION AND TRAINING

Proprietary and Confidential

AGENDA

1. Corrected Claims vs. Inquiries vs. Appeals
2. Demonstration of Inquiry Submission System (IASH)

CORRECTED CLAIMS VS. INQUIRIES VS. APPEALS

'Corrected' claims are sometimes referred to as 'replacement' claims

- It is a replacement of a previously submitted claim.
- Changes could be clinical, member information, etc.
- Submit a corrected claim when the original claim has not been rejected within 365 days from date of service.
- Submit 'corrected' claims electronically to expedite the processing.
- For detailed information on how to submit 'corrected' claims refer to <https://provider.carefirst.com/providers/claims/corrected.page?>

Professional Claims - Submit the following in the HIPAA transaction & code set – 837P

- Include a value of '7' (claim frequency type code) in Loop 2300, Segment CLM05-3 (Replacement; replacement of prior claim)
- Include the original Document Control Number (DCN) in Loop 2300, Ref*F8
- Providers should work with their clearinghouse/vendor/ trading partner to make any changes, if needed

Institutional Claims - Submit the following in the HIPAA transaction & code set – 837I

- Include a value of '7' (claim frequency type code) in Loop 2300, Segment CLM05-3 (Replacement; replacement of prior claim)
- Include the original Document Control Number (DCN) in Loop 2300, Ref*F8
- Providers should work with their clearinghouse/vendor/ trading partner to make any changes, if needed

- 'Corrected' claims require manual intervention therefore:
 - 'Corrected' claims do not show up on CareFirst Direct or the VRU CareFirst On Call when initially received
 - Allow 30 days before doing follow-up on the status of a 'corrected' claim
 - Information on the claims will be available on the self-service tools once adjudication is complete

Corrected Claim on Paper

- Only providers without electronic claim submission capability should submit 'corrected' claims on paper following established procedures
- **Do not** submit a 'corrected' claim with a Provider Inquiry Resolution Form (PIRF)
- Write '**Corrected Claim**' on the top of the claim form
- Mail to the appropriate claims address for member
- **Do not** mail to the correspondence address
- For detailed information on how to submit 'corrected' claims refer to www.carefirst.com/providers > Resources tab > Corrected Claims

- A 'corrected' claim is not an appeal
- An *appeal (grievance)* is a formal written request for reconsideration of a medical or contractually adverse decision
- An appeal must be submitted in writing on the Provider's letterhead within 180 days or 6 months from the date of the Explanation of Benefits or adverse decision
 - Submit your appeal to the appropriate correspondence address
 - **Do not** use a Provider Inquiry Resolution Form (PIRF) form for an appeal
 - Submit additional medical documentation that may assist with the appeal
 - Allow 30 days for a response to an appeal
- For detailed information on how to submit appeals refer to www.carefirst.com/inquiriesandappeals

An Appeal Must Include...

- Patient's first and last name
- Identification number
- Claim number
- Admission and discharge dates or dates of service
- Copy of the original Explanation of Benefits (EOB) denial information and/or denial letter
- Supporting clinical notes or medical records

- A 'expedited appeal' should only be submitted when a delay in receiving health services could seriously jeopardize the life or health of the member, the member's ability to function or cause the member to be a danger to self or others
- Request an expedited appeal is for reconsideration of an medical or contractually adverse decision
- Appeals are reviewed by a physician not involved in the initial denial determination
- Fax expedited appeals to 410-528-7053
- CareFirst will respond to the expedited appeal within 24 hours
- For more information on appeals, visit www.carefirst.com/inquiriesandappeals

- A 'corrected' claim is not an inquiry

- An *inquiry* is a request to review or explain why a claim was processed or paid a certain way and could pertain to authorizations, correct frequency, ICD-10, medical records, procedure/code and referrals
 - Before sending an inquiry consider submitting a corrected claim
 - It is informal and is not subject to official state laws that govern the appeals procedures
 - You have 180 days or 6 months from the date of the Explanation of Benefits or adverse decision to submit an inquiry
 - Allow 30 days for a response to an inquiry

- How to submit an inquiry
 - CareFirst Direct – Submit inquiries through the Claims Inquiry Analysis & Control System (IASH)

 - Written inquiry
 - ✓ Use the '*Provider Inquiry Resolution Form*' (PIRF)
 - ✓ Form is available online at www.carefirst.com/providers > Quick Links – Forms - Administrative

Provider Inquiry Resolution Form



Send inquiries to the appropriate address listed on the form

A copy of this form can be located on the website at www.carefirst.com/providers > Quick Links – Forms > Administrative



CareFirst
Family of health care plans

Provider Inquiry Resolution Form

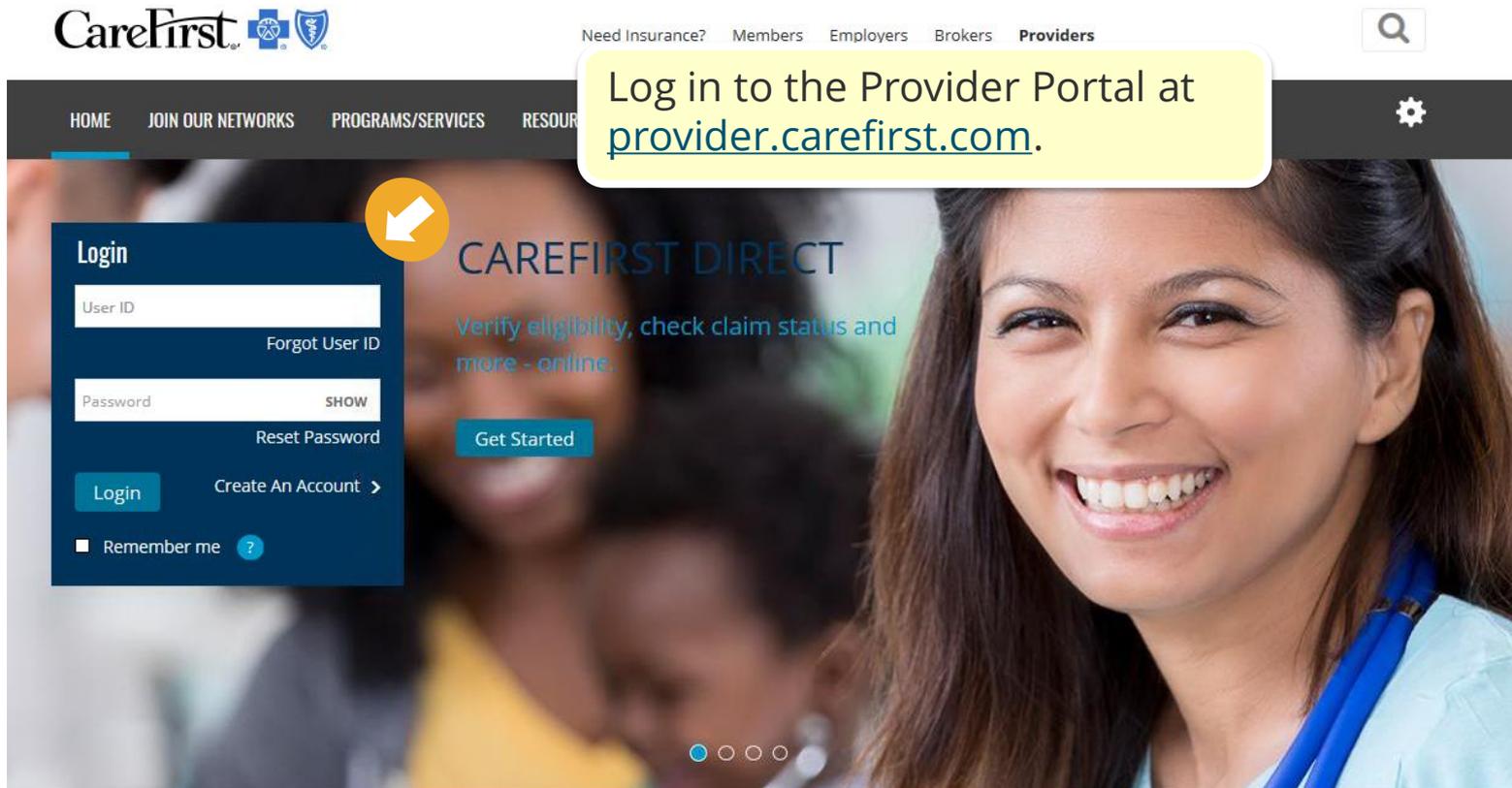
INSTRUCTIONS					
<p>Important: Do not use this form for Appeals or corrected claims. This form is to be used for Inquiries only.</p> <p>For more information on submitting Inquiries and Appeals, please visit carefirst.com/inquiriesandappeals.</p> <p>Helpful Tips:</p> <ul style="list-style-type: none"> ■ Use a separate form for each patient ■ Include the entire subscriber identification number, including the prefix ■ Attach a copy of the claim with any additional information that might assist in the review process ■ Please allow 30 days for a response 	<p>FOR PROVIDER USE ONLY</p> <p>To help expedite your Inquiry, please complete this form and attach all relevant claim information (claim, EOB, operative notes, etc.) and send to the address below that corresponds to the member's insurance coverage.</p> <ul style="list-style-type: none"> ■ MD, NCA, BlueChoice, local BlueCard and NASCO Correspondence (Providers submitting non-FEP inquiries) Mail Administrator P.O. Box 14114 Lexington, KY 40512-4114 ■ FEP—Federal Employee Program (Providers in Montgomery & Prince Georges counties, Washington, DC and Northern Virginia) Mail Administrator P.O. Box 14112 Lexington, KY 40512-4112 ■ All Other MD FEP Inquiries Mail Administrator P.O. Box 14111 Lexington, KY 40512-4111 <p>Visit carefirst.com/providerforms to download a copy of this form.</p>				
INFORMATION					
Date					
Provider/Practice Name & Address	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Provider/Rendering #</td> <td style="width: 50%;">NPI</td> </tr> <tr> <td colspan="2">Email Address for Accounts Receivable</td> </tr> </table>	Provider/Rendering #	NPI	Email Address for Accounts Receivable	
Provider/Rendering #	NPI				
Email Address for Accounts Receivable					
Prefix and Subscriber ID	Claim #				
Patient First Name	Patient Last Name				
From Date of Service	To Date of Service				
Patient Account #	Total Claim Charge				
Reason for Your Inquiry					
Provider Type <input type="checkbox"/> Ancillary <input type="checkbox"/> Dental <input type="checkbox"/> Institutional <input type="checkbox"/> Professional <input type="checkbox"/> Other					
Contact Person	Contact Telephone #				
Contact Email Address					

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CUT7087-1E (7/18)

DEMONSTRATION OF INQUIRY SUBMISSION SYSTEM (IASH)



Log in to the Provider Portal at provider.carefirst.com.

Medical Policy

Find approved medical policies and operating procedures for all products offered by CareFirst in the online Medical Policy Reference Manual.

Forgot your User Id?

- Click **Forgot User ID** and complete the steps to have it sent to your email.

Need to Reset your Password?

- Click **Reset Password** enter your User ID and check your email to complete the password reset. *Note: this must be completed within 24 hours or a new password reset must be initiated.*

To begin click on [Claim Inquiry \(IASH\)](#).

The screenshot shows the CareFirst website interface. At the top left is the CareFirst logo. Below it is a 'Welcome' message. A navigation bar contains five buttons: 'CareFirst Direct', 'Prior Auth / Notifications', 'Referrals', 'Programs/Services', and 'Resources'. A dropdown menu is open under 'CareFirst Direct', listing 'Services', 'CareFirst Direct Home', 'Authorization', 'Claim Inquiry (IASH)', and 'Provider Credentialing'. A yellow callout box with a white arrow points to the 'Claim Inquiry (IASH)' link. Below the navigation is a search area with a 'Find by Member ID' button. The search form includes three required fields: 'Member ID *' (containing 'ABC123456789'), 'Date of Birth *' (with a placeholder 'mm/dd/yyyy'), and 'Date Of Service *' (containing '11/08/2017'). A 'Next' button is at the bottom. A timestamp 'Nov 8, 2017 at 2:47 PM' is visible on the right side of the page.

Help Exit IASH

Welcome to Inquiry Analysis and Control System (IASH)

Home
Add Inquiry
Update Inquiry
Delete Inquiry
Still in Processing
Returned Responses
Last 6 Months

Welcome to IASH Home Page Oct 2, 2017, 3:34 PM

Select Tax ID

SELECT ONE ▼

Select Provider

SELECT ONE ▼

Functions Provided by IASH - Inquiry Analysis & Control System:

- ❖ [Add a new inquiry](#)
- ❖ [Update](#) an existing inquiry
- ❖ [Delete](#) an existing inquiry
- ❖ [Still in Processing](#) retrieves a roster of the provider's or billing agency's inquiries not returned by CareFirst
- ❖ [Returned Responses](#) retrieves a roster of the provider's or billing agency's inquiries returned by CareFirst, but not yet signed off by the provider or billing agent
- ❖ [Last 6 Months](#) retrieves a roster of all the provider's or billing agency's inquiries (opened and closed)
- ❖ [IASH Fax Form](#) Please use when sending supporting documentation.

Select a *'Tax Id'* (if you have access to more than one) and a *'Provider'* to add click [Add a new inquiry](#).

Note: The IASH Fax Form link should be used when sending supporting documentation.

Add Inquiry

Enter the membership number to initiate the inquiry and click 'Create Inquiry'.

Initiate Provider Inquiry

NOTE: The ID Number may be different from the ID number you entered on the request. Please contact the Subscriber/Member to verify their information and for a copy of their NEW ID Card.

Do not use IASH to add any inquiry that requires clinical review. For more information on Inquiries & Appeals, click [here](#).

*Member Id

999999999 x

Clear

Create Inquiry



Add Inquiry

Enter Provider Inquiry

NOTE: The ID Number may be different from the ID number you entered on the Subscriber/Member to verify their information and for a copy of their NEW ID Card.

BCBSNCA ID	Control Number	Group Number	
<input type="text" value="900999999"/>	<input type="text" value="0712345678"/>	<input type="text" value="7J53"/>	
Subscriber	Provider Number	Date Entered	
<input type="text" value="Jane Doe"/>	<input type="text" value="E999"/>	<input type="text" value="04/11/07"/>	
*Patient Account #	Patient First Name	Service From	Service To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		mm/dd/yy	mm/dd/yy

Please include the control number of this inquiry on any supporting documents sent or faxed to CareFirst.

*Inquirer's Name	*Telephone Number
<input type="text"/>	<input type="text"/> <input type="text"/> Ext <input type="text"/>

Question

Clear

Cancel

Add Inquiry

The fields you see filled in will auto-populate for you.

Take note of the Control Number.

Add Inquiry

Enter Provider Inquiry

NOTE: The ID Number may be different from the ID number you entered on the request. Please contact the Subscriber/Member to verify their information and for a copy of their NEW ID Card.

BCBSNCA ID	Control Number	Group Number	
<input type="text" value="900999999"/>	<input type="text" value="0712345678"/>	<input type="text" value="7J53"/>	
Subscriber	Provider Number	Date Entered	
<input type="text" value="Jane Doe"/>	<input type="text" value="E999"/>	<input type="text" value="04/11/07"/>	
*Patient Account #	Patient First Name	Service From	Service To
<input type="text" value="LAB555"/>	<input type="text" value="Jane"/>	<input type="text" value="03/10/07"/>	<input type="text" value="03/10/07"/>
		<small>mm/dd/yy</small>	<small>mm/dd/yy</small>

Please include the control number of this inquiry on any supporting documents sent or faxed to CareFirst.

*Inquirer's Name	*Telephone Number		
<input type="text" value="Sally Smith"/>	<input type="text" value="410"/>	<input type="text" value="555-1212"/>	Ext <input type="text" value="123"/>

Question

Complete the remaining fields.



Add Inquiry

Enter Provider Inquiry

NOTE: The ID Number may be different from the ID number you entered on the request. Please contact the Subscriber/Member to verify their information and for a copy of their NEW ID Card.

BCBSNCA ID	Control Number	Group Number	
<input type="text" value="900999999"/>	<input type="text" value="0712345678"/>	<input type="text" value="7J53"/>	
Subscriber	Provider Number	Date Entered	
<input type="text" value="Jane Doe"/>	<input type="text" value="E999"/>	<input type="text" value="04/11/07"/>	
*Patient Account #	Patient First Name	Service From	Service To
<input type="text" value="LAB555"/>	<input type="text" value="Jane"/>	<input type="text" value="03/10/07"/>	<input type="text" value="03/10/07"/>

mm/dd/yy

Please include the control number of this inquiry on any supporting documents sent or faxed to CareFirst.

*Inquirer's Name	*Telephone Number
<input type="text" value="Sally Smith"/>	<input type="text" value="410"/> <input type="text" value="555-1212"/> Ext <input type="text" value="123"/>

Question

Claim submitted with the wrong procedure code 88061. Correct procedure is 88062. Submitting corrected claim. Please reprocess. Thanks, Sally.

Be as specific as possible with your question/request.

Once all fields are completed, click *'Add Inquiry'*.



CareFirst

Welcome to Inquiry Analysis and Control System (IASH)

Home Add Inquiry Update Inquiry Delete Inquiry Still in Processing Returned Responses

Welcome to IASH Home Page Oct 2, 2017, 3:34 PM

Select Tax ID Select Provider

Functions Provided by IASH - Inquiry Analysis & Control System:

- ◊ [Add](#) a new inquiry
- ◊ [Update](#) an existing inquiry
- ◊ [Delete](#) an existing inquiry
- ◊ [Still in Processing](#) retrieves a roster of the provider's or billing agency's inquiries not returned by CareFirst
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- ◊ [Last 6 Months](#) retrieves a roster of all the provider's or billing agency's inquiries (opened and closed)
- ◊ [IASH Fax Form](#) Please use when sending supporting documentation.



If you need to send an attachment with your inquiry print the IASH Fax Form (located on the IASH home page).

- Use it as a cover sheet for your attachment.
- Please note the control number on all pages of your fax.
- Be sure to fax it to the correct number.
- Your attachment will be matched with your inquiry.

Note: all fields are required.

IASH Fax Sheet

This form helps support your inquiry to the CareFirst Direct Inquiry Analysis and Control System. Please use this form when faxing your documents.

Date: _____ Time: _____

To: IASH Inquiries Unit Fax: _____

From: _____ Office Phone: _____

of pages: _____ Office Fax: _____
(including cover)

Fax to Appropriate Number Listed Below:

FEP	FACETS	NASCO/BlueCard
<input type="checkbox"/> UB04 Billers MD* 410-561-7933	<input type="checkbox"/> UB04 Billers 301-470-1890	<input type="checkbox"/> 301-470-5157
<input type="checkbox"/> CMS 1500 Billers MD* 410-561-7933	<input type="checkbox"/> CMS 1500 Billers 301-470-8072	
<input type="checkbox"/> UB04 Billers DC 301-470-5152		
<input type="checkbox"/> CMS 1500 Billers DC 202-203-2209 OR 202-203-2236		

*Excludes PG and Montgomery Counties, use UB04 Billers DC and CMS 1500 Billers DC fax numbers.

Required Information

Provider ID# _____

Number _____

Confidentiality Notice

this communication could be a violation of Federal and State Law. This communication and any files sent and may contain protected health information. This communication is solely for the use of the individual named. If you are not the intended recipient, any use, distribution, printing or acting in reliance on this information is strictly prohibited. If you have received this message in error, please notify the sender and destroy this communication.

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DEMONSTRATION OF SYSTEM NASCO/BLUECARD INQUIRIES

CareFirst Welcome Help Settings Log Out

CareFirst Direct | **Claims Status Results** | Claim Status Summary

Eligibility / Benefits & Claims Status | Remittance / NOP | Fee Schedules

< Back **Claim Status Summary** Sep 11, 2017, 9:16 AM

MEMBER LAST NAME, FIRST NAME | DOB : 02/01/1965 (52 yrs) Female | Member ID: ABC123456789

Medical

Claim Information

Claim Number 111111111111111	Claim Other Blue Number N/A	Claim Adjusted? No
Claim Status F1 - Finalized / Payment 65 - Claimline has been paid.	Date of Service 03/01/2017 - 03/01/2017	Adjudication Date 03/04/2019
Check/ EFT Date 03/04/2019	Check/ EFT Number 000000	System Source NASCO

Provider Information

Provider Name/Provider Id PROVIDER NAME XXXXXXXXXX	Tax ID 111111111	Pay to NPI 000000000
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	Amount		Amount
Total Charges	\$16,000.00	Deductible Amount	\$0.00
Total Non-Allowed amount	N/A	Copay Amount	\$0.00
Total Allowed amount	\$15,271.88	Coinsurance Amount	\$0.00
Total Paid Amount	\$15,271.88	COB Amount	\$0.00
Total Member Responsibility	\$0.00	Penalty Amount	\$0.00

Line No	Revenue Code	Total Charge	Allowed charges	Paid Amount	Member Liability	Date of Service	Place of Service
0010	0210	\$8,000.00	\$15,271.88	\$15,271.88	\$0.00	03/01/2017-03/01/2017	1 - Hospital inpatient
0020	0260	\$8,000.00	\$0.00	\$0.00	\$0.00	03/01/2017-03/01/2017	1 - Hospital inpatient

* N/A : Not Available

I would like to

- View Eligibility
- Prior Auth/Notifications
- Submit Claim Inquiry**
- New Member Search

To initiate an inquiry, click on *'Submit Claim Inquiry'* directly from the Claim Summary Screen under the *'I would like to'* heading.



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CareFirst Direct

Prior Auth / Notifications

Referrals

Programs/Services

Resources

Information Request

Summary Information



You will notice that the Provider Information, Member Information and Claim Information auto-populates.

Provider Information

Payee Name, Provider ID	Entry Date
Provider Name xxxxxx	10/2/2017

Member Information

Member First/Last Name	Member ID	Member Account #	Source System
Member Name	XXXXXXXX	111111111	NASCO

Claim Information

Claim Number	Claim Amount	Claim Service Date Range	Claim Status
1111111111111111	\$16,000.00	03/01/2017 - 03/01/2017	F1 - Finalized / Payment

All Inquiries must be submitted within 180 days from the receipt date. Carefirst may require additional information from the provider. The inquiry must be subject to medical review.

Inquirer's Information

Inquirer's Name *	Phone Number *	Ext.	
<input type="text" value="John Doe"/>	<input type="text" value="(000)000-0000"/>	<input type="text" value="000"/>	
Mailing Address *	Mailing Address 2		
<input type="text"/>	<input type="text"/>		
City *	State *	Zip Code *	Email Address (Optional)
<input type="text" value="City"/>	<input type="text"/>	<input type="text" value="Zip Code"/>	<input type="text" value="abcd@company.com"/>

Inquirer's Information

Inquirer's Name * Phone Number * Ext.

Mailing Address * Mailing Address 2

City * State * Zip Code * Email Address (Optional)

Additional Inquiry Information

Reason for Inquiry * Additional Information *

If Accident, Date of Accident Medicare HIC Number

Multiple Claims? Yes No

Please provide a detailed explanation for this inquiry in the field provided below. * Max Space 480 Characters

* Required

You will need to complete the **Inquirer's Information**, as well as the **Additional Inquiry Information** fields.

Be as specific as possible with your request.

When you have entered all of the required information, click **'Submit'**.



Welcome

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| **A A A**

CareFirst Direct

Prior Auth / Notifications

Referrals

Programs/Services

Resources

Thank you for your submission. If additional information regarding this inquiry is needed, you will be contacted in writing. If you need to contact us about this inquiry, please contact the appropriate Provider Service Center.

Mail Administrator
P.O. Box 14114
Lexington, KY 40512 -4114

For all claim inquiries you must provide the following information:

Oct 2, 2017, 12:00 AM

Control Number:	xxxxxxxxxxx
Member First Name:	Member name
Member Last Name:	Member name
Provider ID:	XXXXXXX
Provider Name:	Provider name
Member Account #:	XXXXXXXXX
Source System:	NASCO
Claim Number #:	111111111111111
Claim Amount:	\$16,000.00
Claim Service Date Range:	2017-03-01 2017-03-01
Claim Status:	F1 - Finalized / Payment
Inquirer's Name:	John
Phone Number :	410-555-5555
Mailing Address:	145 Any Street, Columbia, MD 21044
Email Address:	N/A
Reason for Inquiry:	ReviewAmountPaid
Additional Information:	Other
Inquiry Description:	Amount paid on claim #999999999ZZ99 does not reflect fee schedule amount. Please review. Thanks, Sally.

Please print this form and retain a copy for your records. You will need the control number to follow up with Carefirst about your inquiry. Please include the control number of this inquiry on any supporting documents mailed or faxed to Carefirst.

Inquiries can be faxed to 301-470-5157



THANK YOU

For more information, contact

YOUR PROVIDER RELATIONS REPRESENTATIVE