



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Appealing a clinical editing denial: Instructions

Blue Cross commercial, Medicare Plus BlueSM, BCN commercial and BCN AdvantageSM

November 2024

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This document contains instructions on how to process a clinical editing appeal. The instructions are both for providers who are not contracted with Blue Cross Blue Shield of Michigan and Blue Care Network and for those who are.

For providers not contracted with Blue Cross or BCN

Providers who are not contracted with Blue Cross or BCN should follow these instructions:

- For Medicare Plus Blue claims, submit clinical editing appeals to:
 - Blue Cross Blue Shield of Michigan
 - Medicare Plus Blue Grievance and Appeals Department
 - P.O. Box 2627
 - Detroit, MI 48231-2627
 - Fax: 1-877-348-2251
- For BCN Advantage claims, submit clinical editing appeals to:
 - BCN Advantage Appeals and Grievance Unit
 - P.O. Box 44200
 - Detroit, MI 48244-0191
 - Fax: 1-866-522-7345
- For Blue Cross commercial and BCN commercial claims, submit clinical editing appeals using the instructions provided in the “For providers contracted with Blue Cross and BCN and for noncontracted providers handling commercial clinical editing denials” section of this document.

For providers contracted with Blue Cross and BCN and for noncontracted providers handling commercial clinical editing denials

Access the pertinent documents

When deciding whether to appeal a clinical editing denial, you should first review the pertinent documents, which are identified in this section and which can be accessed by following these steps:

1. Log in to our provider portal (availability.com*).
2. On the *Payer Spaces* menu, click the BCBSM and BCN logo.
3. Click the Resources tab and then click *Secure Provider Resources (Blue Cross and BCN)*.
4. On the *Billing and Claims* menu, click *Codes and Criteria*. Look under the “Clinical Editing” heading.

Gather information about whether to submit a corrected claim or appeal the clinical editing denial

Before deciding whether to submit a corrected claim or appeal the clinical editing denial, there are documents you should review and things you should be aware of.

Review the document *Clinical edits: What you need to do and what documentation is needed*

This document offers useful information on various types of clinical editing denials and on whether to submit a corrected claim or appeal the clinical editing denial, including what types of documentation you’ll need to submit with the appeal. This document applies to all lines of business.

You can locate this document on our secure Provider Resources website by completing the steps outlined in the “Access the pertinent documents” section.

Be aware of other important information

For all clinical editing appeals:

- Re-read the language associated with the EX code and make sure you understand what it says.
- Appeals must be submitted within 180 days of the date on the original remittance advice with the original clinical editing denial on it. If the appeal is not received within that time frame, it will not be accepted and you will not have another opportunity to appeal.

- If there are multiple edits or dates of service on one claim, these should be submitted all at one time, either through Availity or on one appeal form.
- Documentation supporting the appeal must be submitted with the appeal. What is required may vary on the service being appealed. For example, office services that were denied may require office notes; services denied as duplicates will require records for both the denied and the paid service to show that more than one was performed; and denied surgical services may require operative reports. You should submit the documentation appropriate to the procedure code that was denied and the denial reason.

Take other considerations into account: Blue Cross commercial

For Blue Cross commercial claims, review the document *EX Codes: Recommendations Regarding Appeal or Resubmission (for Blue Cross commercial)*. This document lists the reasons for clinical editing denials and recommendations on what to do for each.

In addition, be aware that if the first clinical editing appeal is denied, you can submit a second-level appeal using the *Managerial Review Request Form*. The second level of appeal must be submitted within 60 days of the date on the denial letter you receive for the first appeal.

Important: The second level of appeal is available for Blue Cross commercial claims only.

You can locate these documents on our secure Provider Resources website by completing the steps outlined in the “Access the pertinent documents” section.

Take other considerations into account: Medicare Plus Blue

For Medicare Plus Blue claims, Explanation of Payment codes 852, 870 and 871 are the only EOP codes that indicate that a claim has been denied for clinical editing. If you see these EOP codes on the Remittance Advice, you can submit a clinical editing appeal.

In addition, be aware that there’s only one level of clinical editing appeal. A claim denied for a clinical edit can be appealed only one time.

Take other considerations into account: BCN commercial and BCN Advantage

For BCN commercial and BCN Advantage claims, review these documents:

- *EX Codes: Recommendations Regarding Appeal or Resubmission (for BCN commercial and BCN Advantage)* — lists the reasons for clinical editing denials and recommendations on what to do for each
- *Appropriate modifier usage (for BCN commercial and BCN Advantage)* — offers guidelines on appropriate use of modifiers to help you determine whether inappropriate modifier usage may have been a reason for the denial

- *Drugs and Biologicals: Correct Coding and Reporting of Services* (for BCN Advantage only) — offers guidelines on indications for the appropriate use, dosing limits and frequency of administration for the drugs and biologicals identified.

You can locate these documents in our secure Provider Resources area by completing the steps outlined in the “Access the pertinent documents” section.

In addition, be aware that there’s only one level of appeal. A claim denied for a clinical edit can be appealed only one time.

Make the decision whether to submit a corrected claim or appeal the clinical editing denial

Once you’ve reviewed the pertinent information, make the decision whether to:

- Submit a corrected claim. For more information, refer to the section titled “How to submit a corrected claim”.
- Submit a clinical editing appeal. For more information, refer to the section titled “How to submit a clinical editing appeal”.

How to submit a corrected claim

You can submit a corrected claim in one of these ways:

- Through [availity.com](https://www.availity.com)*
- Using the appropriate electronic standard transaction:
 - Professional billers can submit a corrected claim electronically via the 837P transaction standard. When rebilling electronically, make sure to report the appropriate Claim Frequency Type Code (use a “7” to replace the original claim) in Loop 2300 CLM05-3 data element.
 - Facility billers can submit a corrected claim electronically via the 837I transaction standard. Please ensure that the last position of the Type of Bill, reported in Loop 2300 CLM05, reflects the appropriate Claim Frequency Type Code in the CLM05-3 data element, as per NUBC billing guidelines.

How to submit a clinical editing appeal

You can submit a clinical editing appeal in one of two ways:

- Electronically, through [availity.com](https://www.availity.com)*
- Using the *Clinical Editing Appeal Form*

Keep reading for additional information.

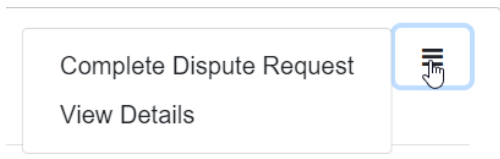
Submit an appeal electronically, through Availity

To submit a clinical editing appeal electronically:

1. Log in to [availity.com](https://www.availity.com)*
2. On the Claims & Payments menu, click *Claim Status* and follow the prompts to locate the claim for which you want to appeal a clinical editing denial.
3. On the claim, click *Claim Dispute*. This initiates the appeal.

Note: If you want to initiate appeals on additional claims, click *Close* to return to the Claim Status results page. To continue your appeal of the claim in question, complete the additional steps outlined here.

4. Click *Go To Request* to open the Appeals application and access the request in “Initiated” status.
5. On the action menu at the top right of the claim, click *Complete Dispute Request*.



6. In the dialog box that opens:
 - a. Enter data into the fields.

Important: In the field shown below, enter this information:

- What you're appealing
- Your reason for appealing
- Your return address (that is, an address to which we can send a determination letter through the U.S. mail)

* Please explain the supporting rationale for your request.
(Specific details for current appeal, including Procedure/EX codes and return address)

Note: If you don't enter all the required information into this field, your clinical editing appeal request will be returned without review.

- b. Click *Add File* and upload the pertinent documentation.
- c. Click *Submit Request*.

Your request will be sent for processing by the Blue Cross / BCN clinical editing staff.

Submit an appeal using the *Clinical Editing Appeal Form*

Here's how to prepare and submit the *Clinical Editing Appeal Form*:

1. Access the [Clinical Editing Appeal Form](#).
2. Enter information into every pertinent field (1 through 16) on the *Clinical Editing Appeal Form*.

Note: Be sure to complete all the required fields, which are marked with a red asterisk. If you don't complete all the required fields, your clinical editing appeal request will be returned without review. This includes the "reason / rationale for appeal" field, into which you must enter:

- What you're appealing
 - Your reason for appealing
 - Your return address (that is, an address to which we can send a determination letter through the U.S. mail)
3. Gather the supporting documentation of the kind listed in field 17 on the form:
 - Chart or office notes, when the code being appealed refers to an office visit or a service provided in the office
 - Operative notes or surgery reports, when the procedure code being appealed refers to a surgery
 - X-ray reports, when an X-ray is being appealed
 - Lab or pathology reports, when a laboratory or pathology service is being appealed
 - Other clinical documentation related to the procedure being appealed
 4. Submit the completed appeal form and the supporting documentation as indicated on the form. Keep a copy in case any questions come up.

How to check the status of a clinical editing appeal and request a copy of the appeal resolution

To check the status of a clinical editing appeal you submitted and request a copy of the resolution, do the following:

If you submitted the clinical editing appeal through Availity, you can check the status of the appeal in Availity. Do the following:

1. Log in to [availity.com](https://www.availity.com)*
2. On the Claims & Payments menu, click *Appeals*.
3. Locate the claim for which you submitted a clinical editing appeal.

Availity will show the status of the appeal, as follows:

- In Process
- Finalized - Clinical Edit Appeal – Upheld. This means that we denied the provider’s appeal of the clinical edit. A copy of the denial letter will be accessible through Availity.
- Finalized - Clinical Edit Appeal – Overturned. This means that we approved the provider’s appeal of the clinical edit. We’ll process the appropriate reimbursement. Check the Remittance Advice.

If you submitted the appeal using the *Clinical Editing Appeal Form*, you can check the status through Provider Inquiry, as follows:

- Blue Cross commercial: Call 1-800-344-8525 (professional providers) or 1-800-249-5103 (facilities)
- Medicare Plus Blue: Call 1-866-309-1719
- BCN commercial or BCN Advantage: Call Provider Inquiry using one of the numbers on the [Contact Us](#) webpage. Select *Blue Care Network* for the plan type and then select *Provider Inquiry* for the topic.

Note: If you submitted the clinical editing appeal through Availity, you can still call Provider Inquiry to check the status.

Here’s what Provider Inquiry will do:

- If there is no record of an appeal and it’s been at least 30 days since you’ve submitted it, Provider Inquiry will advise you to resubmit the appeal.
- If the status of the appeal is shown as pending, Provider Inquiry will advise you to wait for the resolution, as an appeal may take up to 60 business days to process.
- If the record of the appeal is located and a determination has been made on it, Provider Inquiry will inform you of the determination, as follows:
 - If the appeal was approved, Provider Inquiry will advise you that the claim was sent for reprocessing.



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- If the appeal was denied, Provider Inquiry can send you a copy of the denial letter or let you know that you that the letter is being processed but is not yet ready for sending.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.

Availity[®] is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.