Claims Troubleshooting: Blue Cross Complete

September 2016

You can resolve a claim problem more quickly and efficiently using the approaches described below, for the most frequently encountered problems.

Situation	What to do
1. You do not get a response after claim submission…	You can check the status of a claim at any time using NaviNet®. Visit **NaviNet.net** > Login. If you have a question about the claim, you can call Blue Cross Complete Provider Inquiry at 1-888-312-5713.
2. You do not see any record of a claim you submitted…	Call Blue Cross Complete Provider Inquiry at 1-888-312-5713. If the claim needs to be reprocessed, the reprocessing will be done during the phone call, if possible. In addition: • If the information on the claim was incorrect, a corrected claim may be submitted. • If there is an issue with medical necessity determination, the claim may be appealed.
3. You receive a claim return letter describing claim defects that must be corrected or if the electronic claim was listed in the 277CA report…	Submit a corrected claim either on paper (using a CMS-1500 form for professional claims or a UB-04 form for facility claims) or via electronic data interchange. A corrected claim in one that is resubmitted with a specific change made, such as a different procedure code, diagnosis code or billed amount. A claim should not be submitted as corrected simply to review how that claim was processed during its initial submission. Refer to the *Blue Cross Complete Provider Manual* for guidelines for submitting a corrected claim.
4. You get a Remittance Advice showing a negative balance…	A negative balance is created when Blue Cross Complete pays you for services and later discovers this payment was incorrect. You may have already processed the payment before the error was caught. When payment is made in error, Blue Cross Complete takes steps to recover the incorrect payment in accordance with the terms contained in the provider agreement. Some common reasons for incorrect payments include the following: • The provider was overpaid for the service rendered due to billing or processing errors. • The provider was paid in error because of the member's ineligibility or because the services was not authorized. • It is determined that the member had other insurance that was primary.
5. You want to appeal a denied claim…	Submit an appeal within 30 days of the decision on the claim. Note: • If the reason for the denial is related to timely filing, you are required to submit supporting documentation showing that the claim was filed in a timely manner. • If the denial reason is a coding edit (CCI edit denial), you are required to submit supporting documentation and medical notes or reports. • If the denial reason is the payment amount, you are required to submit supporting documentation for the amount. Submit the appeal to: Blue Cross Complete Claims Appeals P.O. Box 7361 London, KY 40742-7361
6. You receive a claim resolution that is not satisfactory or you question how the inquiry was handled…	Call Blue Cross Complete Provider Inquiry at 1-888-312-5713.