The Claim Inquiry Resolution (CIR) tool enables providers to submit claim reconsideration requests electronically for certain finalized claims.* This tool can be used as an alternative option to requesting claim adjustments over the phone or via the Blue Cross and Blue Shield of Oklahoma (BCBSOK) Claim Review Form. Also, this tool reduces administrative costs by decreasing the amount of correspondence that must be sent through the mail.

**Note:** The Claim Inquiry Resolution cannot be used to obtain eligibility and benefit information or claim status. Moreover, it is not a means to submit formal claim appeals or predeterminations. Users can employ this tool for finalized claims that require review relating to reasons outlined in this guide.

***The CIR tool is unavailable for Medicare Advantage claims.***

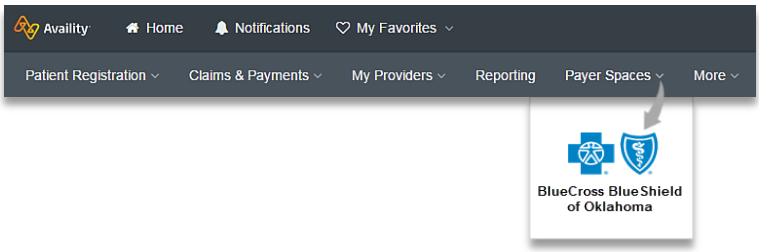
## 1) Getting Started

- Go to Availity
- Select **Availity Portal Login**
- Enter User ID and Password
- Select **Log in**

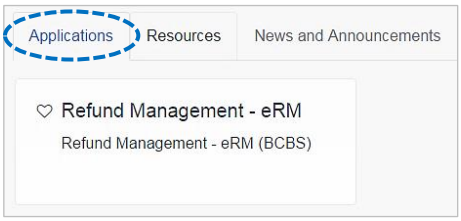

***Note:*** *Only registered Availity users can access Claim Inquiry Resolution.*

## 2) Accessing Claim Inquiry Resolution

- Select **Payer Spaces** from the navigation menu
- Choose **Blue Cross and Blue Shield of Oklahoma**




- In BCBSOK Payer Spaces, select the **Applications** tab
- Next, select **Refund Management - eRM**

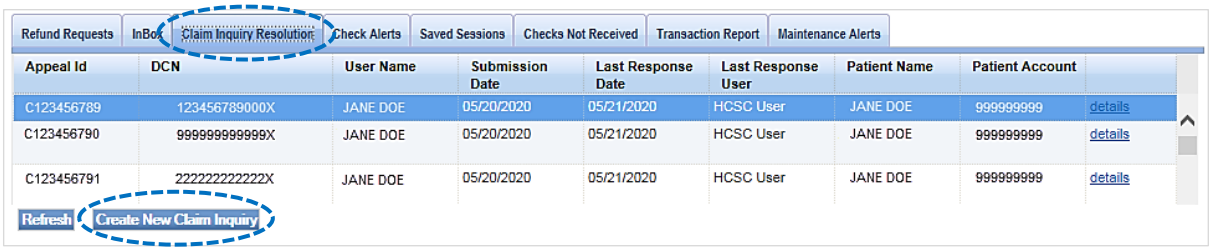



***Notes:***

- *Contact your Availity Administrator if **Refund Management – eRM** is not listed in the Applications menu. Identify your Availity Administrator by referring to **My Administrators** under **My Account Dashboard** on the Availity home page.*
- *New users must complete the onboarding form and email verification in order to gain access to the eRM system.*

## 3) Starting a New Inquiry

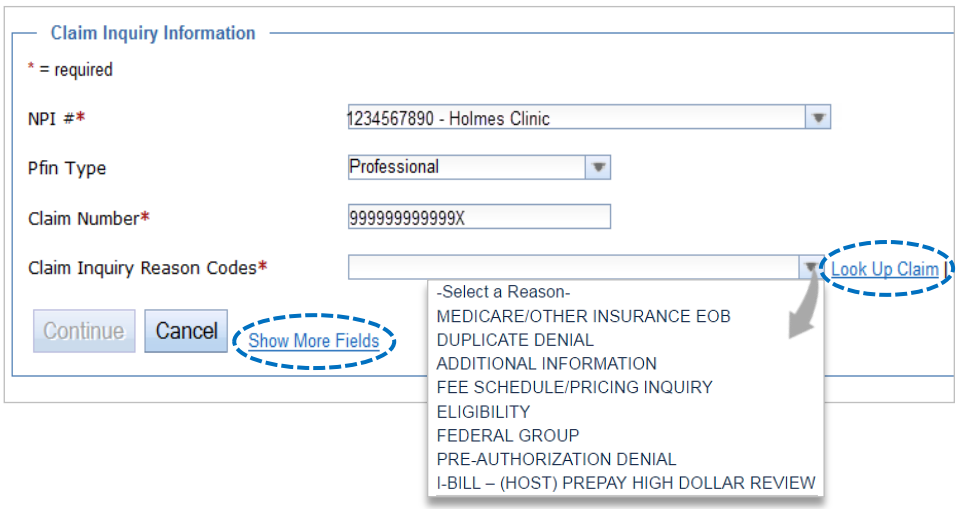
- Select the **Claim Inquiry Resolution** tab
- Select **Create New Claim Inquiry**




## 4) Entering Claim Information

- For the NPI #, select the appropriate Type 2 Billing NPI from the drop-down list
- Enter the **13-digit claim number**
- Select the most applicable reason from the **Claim Inquiry Reason Codes** drop-down list*
- Select **Continue**

**Reference page 5 for a detailed listing of each Claim Inquiry Reason Code.*




***Quick Tips:***

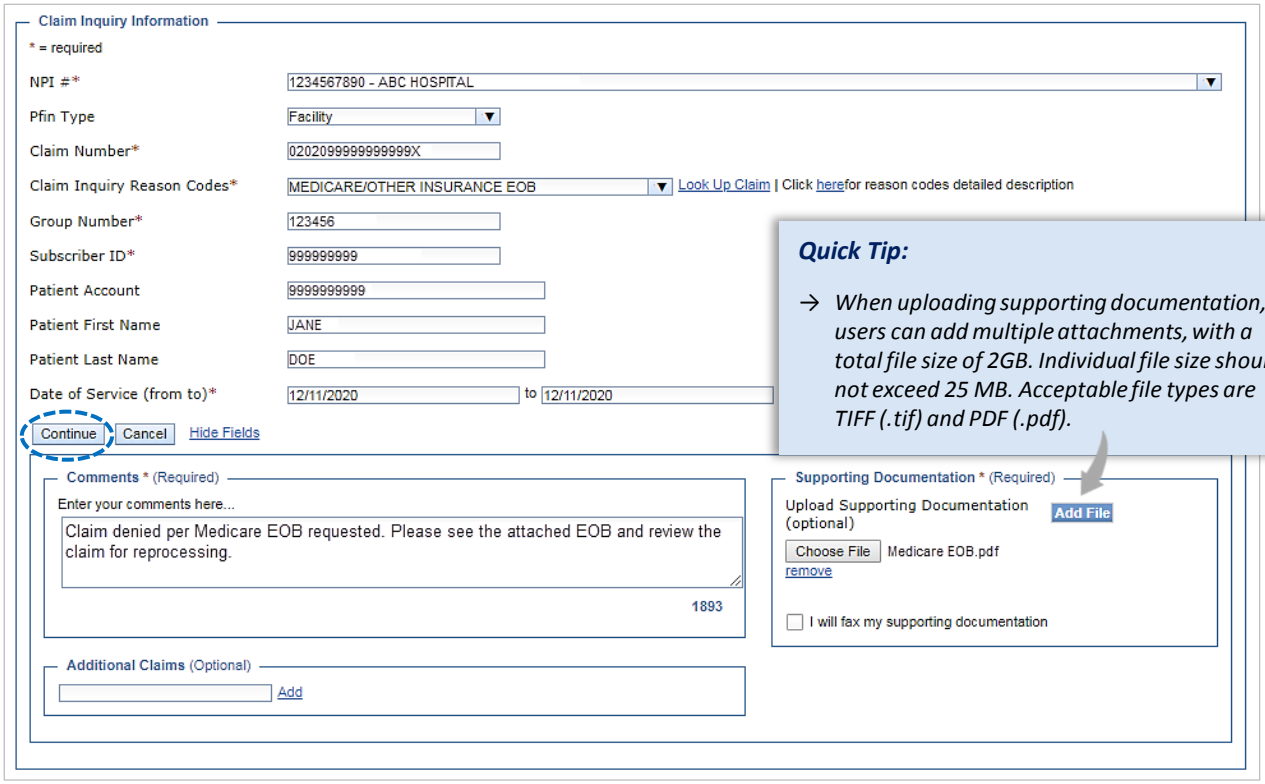
→ *If your claim was processed within the last 18 months, select **Look Up Claim** to populate the Subscriber ID, Group Number, Patient Account, Patient Name and Date of Service on the next screen.*

→ *If your claim processed prior to 18 months, select **Show More Fields** to manually enter this information on the next screen.*

## 5) Supporting Comments and Documentation

- In the **Comments** field, provide a thorough explanation as to why the claim should be reconsidered.
- Additional BCBSOK claim numbers for the same patient/issue that need reconsidered, can be listed in the **Additional Claims** section.
- Supporting documentation is only required if **Medicare / Other Insurance EOB** or **Additional Information** is chosen as the Claim Inquiry Reason Code. However, our staff may request additional information when necessary to continue reconsideration of a claim.
- There are two options for sending supporting documentation to BCBSOK:
  - Select the **Add File** and **Browse** buttons to upload applicable document(s)
  - Select **I will fax my supporting documentation** to fax applicable documentation*
- Select **Continue** to review your inquiry, then select **Submit**.

** A fax cover sheet (including the fax number) will be available for printing after the **Submit** button is selected. This fax cover sheets includes a bar code to help ensure the information you send is matched directly to the appropriate file and/or claim.*




## 6) Claim Inquiry Tracking ID

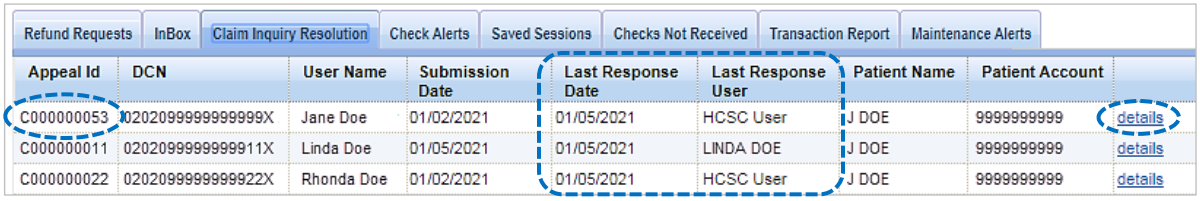
- After the inquiry has been submitted, a **Claim Inquiry Tracking ID** will be provided for monitoring purposes.*

**Your Claim Inquiry Tracking ID is C000000053**

**The Tracking ID is only for reference within the Claim Inquiry Resolution. **BCBSOK Phone Customer Advocates do not utilize this tool**.*

## 7) Tracking Inquiries

- Once a claim inquiry has been submitted, users can monitor BCBSOK's receipt and response by returning to the **Claim Inquiry Resolution** tab.
- The **Last Response Date** and **Last Response User** fields display the date of the last action taken on an inquiry and by whom.
- Select the column headers to sort these fields in ascending and descending order.
- When HCSC is listed as the Last Response User, click the **details** link to view BCBSOK's response to the inquiry.




| Appeal Id | DCN | User Name | Submission Date | Last Response Date | Last Response User | Patient Name | Patient Account | |
|---|---|---|---|---|---|---|---|---|
| C000000053 | 02020999999999999X | Jane Doe | 01/02/2021 | 01/05/2021 | HCSC User | J DOE | 9999999999 | details |
| C000000011 | 02020999999999911X | Linda Doe | 01/05/2021 | 01/05/2021 | LINDA DOE | J DOE | 9999999999 | details |
| C000000022 | 02020999999999922X | Rhonda Doe | 01/02/2021 | 01/05/2021 | HCSC User | J DOE | 9999999999 | details |

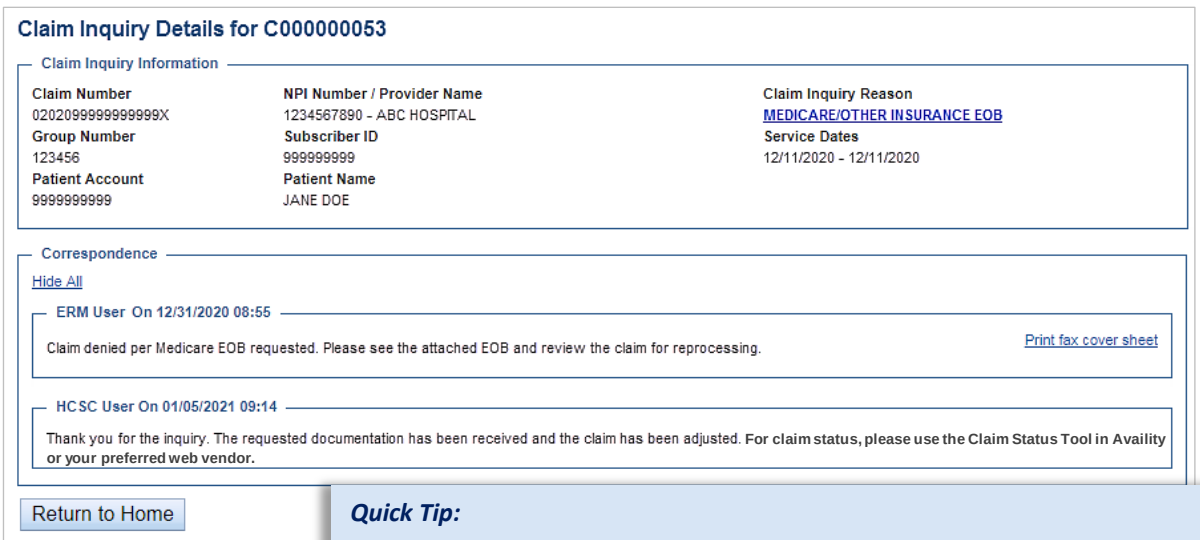
## 8) Advanced Filtering

- Users may also utilize the filter option to search by a specific **Appeal ID Number** (i.e., C000000053).*
- Select **Advanced Options** to sort results by a specific username, patient name, account number, etc.

***** *The Appeal ID Number is the same as the Claim Inquiry Tracking ID.*


## 9) Verifying Responses

- The details screen will display the comments entered on the original inquiry submission as well as BCBSOK's response.




***Quick Tip:***

→ *Open a new CIR inquiry to request clarification or additional updates on the original inquiry.*

## Inquiry Reason Codes

| Inquiry Reason Code | Purpose | Guidelines |
|---|---|---|
| Medicare or Other Insurance EOB | Send Medicare or another insurance's Explanation of Benefits (EOBs) to BCBSOK. | • Attach documents via **Add File** or **I will fax my supporting documentation**.<br>• Use the **Comments** field to indicate if EOBs will be uploaded or faxed.<br><br>***Note:*** *The EOB must be supplied in order for the inquiry to be processed.* |
| Duplicate Denial | Dispute claims that deny as duplicate in error. | • Indicate any previous claim number(s) that may have triggered the duplicate denial.<br>• Include explanation specifying how the claims are different. |
| Additional Information | Submit specific information that was requested in the claim denial.<br>• Medical records<br>• Operation Reports<br>• Physician Notes, etc. | • Attach documents via **Add File** or **I will fax my supporting documentation**.<br>• Use the **Comments** field to indicate if documentation has been uploaded or faxed. |
| Fee Schedule / Pricing Inquiry *(Professional providers)* | Inquire on claims that process differently than contractual agreements. | • Use the **Comments** field to indicate which specific line item did not process correctly. |
| Eligibility | Dispute claims that deny for non-eligible services or process differently than the eligibility quote that was previously received. | • Include eligibility and benefit call reference numbers in the **Comments** field.<br>• Attach screen prints of online eligibility and benefit verification via the **Add File** or **I will fax my supporting documentation**.<br>• Use the **Comments** field to indicate if documentation has been uploaded or faxed. |
| Federal Group | Submit finalized claim inquiries pertaining to Federal Employee Program® (FEP®) members. | • Attach documents via the **Add File** or **I will fax my supporting documentation**.<br>• Use the **Comments** field to indicate if documentation has been uploaded or faxed. |
| Pre-Authorization Denial | Request review of claims that deny for preauthorization when it was not advised as a requirement during the patient's eligibility and benefit quote. | • Supply preauthorization number for claims that deny per no record on file.<br>• Include eligibility and benefit call reference numbers or use the **Add File** or **I will fax my supporting documentation** functions to submit online eligibility and benefit screen prints.<br>• Use the **Comments** field to indicate if documentation has been uploaded or faxed. |
| I-Bill - (HOST) Prepay High Dollar Review | Submit inpatient itemized bill for any BlueCard® member billed at or more than $100,000. | • Attach documents via **Add File** or **I will fax my supporting documentation**.<br>• Use the **Comments** field to indicate if itemized bills have been uploaded or faxed. |

**Have questions or need additional education?** Email the Provider Education Consultants.

**Have questions about the eRM Onboarding process?** Email the eRM Onboarding team.

*Be sure to include your name, direct contact information & Tax ID or billing NPI.*