Bulletin

September 29, 2010

Clarification of timely filing for claims denied for incorrect procedure code/procedure modifier combinations

Summary/History

Blue Cross and Blue Shield of Minnesota (Blue Cross) implemented a change to the coding edit software to deny claims containing incorrect procedure code/procedure modifier combinations on January 22, 2010. While most of the edits were being properly executed, Blue Cross determined that some of the system changes were implemented incorrectly. In late July 2010, Blue Cross implemented the necessary system changes to correct the edits. Blue Cross has recently completed a recovery process to re-adjudicate those claims that had been denied in error. Claims not adjusted require the provider to submit a replacement claim using proper coding of modifier/procedure code combinations.

Complicating this initial problem, Blue Cross discovered that the internal denial message was incorrectly mapped to remittance denial CO 125 from January 22, 2010 until February 26, 2010. For remits produced February 26, 2010 and after, the denial message correctly maps to CO 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing."

As a result of both the incorrect system editing and the brief incorrect remittance message, providers have been unable to determine which of the claims denied in the first 7 months of 2010 were correctly denied and which of the denials would no longer occur due to the system edit correction that was implemented in late July.

Timely filing temporary change

Blue Cross has made a decision to waive timely filing requirements on replacement claims and appeals ONLY for those claims that originally denied with internal Remark Code GMOD for the remainder of 2010. These claims appear on the provider remittance advice with the messages above. Providers can use provider web self-service at **providerhub.com** to validate if the internal rejection code was GMOD and determine if timely filing will be waived for the appeal or replacement claim.

If you have already submitted an appeal or replacement claim for a claim that originally denied GMOD and you have received a denial for timely filing, you may resend it for consideration of payment.

Replacement claims and appeals received on January 1, 2011 and after must adhere to the timely filing requirements of 90 days for appeals and 6 months for replacement claims from the last adjudication date.

Questions?

If you have questions, please contact provider services at **(651) 662-5200** or toll free at **1-800-262-0820**.