Provider information

Bulletin

October 12, 2009

Revision to providers required to support coding changes with documentation as a result of adjustment audit bulletin

The information in this bulletin replaces Provider Bulletin P20-09 titled "Providers required to support coding changes with documentation as a result of adjustment audit" that was issued on July 9, 2009.

Background

The coding area conducted a review and audit of adjustment requests that were received via provider web self-service (PWSS).

The objective was to determine if the requests to change a medical code (HCPCS (CPT or Level II HCPCS), HCPCS modifier, or ICD-9-CM diagnosis) on a service that was previously denied were valid requests. The emphasis was placed on the nature of the adjustment requests for claims that had a policy denial or a coding edit denial.

It was determined that the medical records are needed for review and verification before an adjustment can be made when the denial was due to a coding edit. Blue Cross and Blue Shield of Minnesota and Blue Plus have an obligation to all members for the accuracy of appropriate claim payment for all claims. This is especially important for members with health savings accounts (HSAs), deductible plans, and self-insured plans. Accuracy of claims payment is crucial to all of our members.

Audit results

Several claims were identified containing billing errors and/or overpayments because of the following reasons:

- Providers stated the code was "billed in error" and requested to change the code
- Providers stated to "cancel" the claim and later rebilled the entire claim with changed codes

Coding changes

As a result of the audit, effective immediately through October 18, 2009, Blue Cross will require providers to request an adjustment using the Provider Claim Adjustment/Status Check/Appeal Form, and send supporting documentation for all claims that were previously denied due to a coding edit denial. These types of claims can be identified with denial remark codes that begin with Gxxx (internal remark code found on PWSS). This policy applies to all claims except BlueCard® program claims. Due to the need for medical documentation, providers will no longer be allowed to call provider service or use PWSS to request these type of coding changes, unless the request is for a BlueCard program claim.

Inquiries for all other coding changes, except those for coding edit denials received since July 9, 2009, (the date of the previous provider bulletin) will be processed as requested.

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Distribution: All participating providers
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Electronic replacement claims

Effective October 19, 2009, Blue Cross will begin to accept electronic replacement claims for coding changes; however, we will continue to require documentation to be submitted when you are changing a medical code (HCPCS (CPT or Level II HCPCS), HCPCS modifier, or ICD-9-CM diagnosis), and the original service was denied due to a coding edit denial. The supporting documentation should be sent as an attachment to the replacement claim.

Before October 19, 2009, you may continue to request an adjustment using the the Provider Claim Adjustment/Status Check/Appeal Form to request an adjustment for coding denials; however, you must also include the medical documentation, such as office notes and/or operative notes to support the coding change. The Provider Claim Adjustment/Status Check/Appeal Form and instructions for completing the form are available on **providers.bluecrossmn.com**, select "Forms & publications" then "forms: other."

Questions?

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