BLUE CROSS MINUTES
March 10, 2014 RIC/RAC Meeting

BCBS REPRESENTATIVES PRESENT:
Ms. Jennifer Nelson
Mr. Michael Lombardo
Mr. Chris Dobbs

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: Jennifer Nelson, Michael Lombardo and Doris Dobbs are here for Blue Cross Blue Shield. We've got a couple of questions for them and then they have a presentation to share with us.

1. **The Blue Cross Remittance Notice for the NASCO claims is giving us a Claim Status of 2 (secondary payment) in the 835 electronic remittance when Blue Cross is taking back (reversing) their payments. The Standardized list of adjustment codes from the 835 states the correct Claims Status code to use when reversing a payment is 22. Will Blue Cross please update their remittance process to reflect Claim Status code 22 when reversing a NASCO payment?**

   Response: An old list of claim status codes is being used. An updated list can be obtained from the Washington Publishing website.
   http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/

   Follow up from meeting after review.
   You are correct, there is an issue in the electronic 835 file. It should have been giving a code of 22 but for some reason it was dropping a 2. We will correct the issue.

2. **Can you bill an E/M CPT code for a clinic visit? We know that revenue code 510 is not covered for clinics but if the clinic is billed with 761 it is paid. For clarity should we bill for "clinic" visits at all?**

   Response: Below is our policy on clinic charges. It's located in our facility manual on our website. Clinic charges should be billed under revenue codes 510-529, the only exception to that policy is when the service is render in a treatment room. In that case we do allow revenue code 761 to be billed. Example of that is wound care, it's typically render in a treatment room. Keep in mind clinic charges are non-covered.

   Hospital Clinic Charges
   Clinic Revenue Codes 510-529 are automatically non-covered by Blue Cross and Blue Shield of Alabama. This policy has been in effect since March 1992. It was determined that these codes are most commonly used to bill for physician visits at a hospital, making this charge part of the physician's professional claim. It is not separately billable by the hospital. The patient is not responsible for these charges.

These revenue codes may be considered on secondary contracts, to be determined by specific contract benefits.

https://www.bcbsal.org/providers/helpful/hospitalClinicCharges.pdf

3. **Under the ACA lactation services are covered services under the preventives services offered. Do the lactation consultants have to be certified?**

   Response: The service needs to be rendered by an eligible provider under the contract. When we receive a bill from the hospital, we only see the hospital as the provider of service.

4. **Do you cover Type B ED visits like Medicare (these are emergency departments that are not open 24/7)?**

   Response: Our emergency room benefits is not specific to type A or B like CMS. When the claim comes in it will process under the member's emergency room benefits for regular business members.

5. **Can a physician group bill under reciprocal or locum tenens billing when a newly hired physician is not credentialed and there is a sharp increase of volume and the regular physician is unavailable to provide the visit services?**

   Response: Below is our locum tenens policy. It's also located in our Provider Manual on the website.

   Locum Tenens/Covering Physicians
   Section 4.14 of the Preferred Medical Doctor (PMD) Agreement states in part, "Physician shall not allow non-Preferred physicians or other allied health professionals to bill the Corporation for services using the Physician's Provider Number." Section 4.17 states in part, "Preferred general practice, family practice, internal medicine, geriatrics and OB/GYN physicians will exercise reasonable efforts to arrange for 24 hour, seven day per week call coverage."

   As a general policy, the physician rendering the service should bill with his or her own provider number. In the circumstance of temporary coverage/locum tenens arrangements the physician should exercise reasonable efforts to ensure that the covering physician is PMD.

   In the event that a non-PMD physician must be used, the PMD physician may bill for the non-PMD physician under his/her provider number if the services are provided on a

temporary/non-routine basis such as locum tenens. If the locum tenens or covering physician replaces the physician for more than two weeks, or on a regular, ongoing basis (for example, every weekend), the covering physician should get a provider number through Blue Cross and bill under his/her own provider number. The medical records should reflect the signature style, "Doctor X covering for Doctor Y," as a matter of prudent documentation practices.

Below is a list of modifiers that may be placed on the claim following the procedure code to signify involvement in patient care by someone other than the "regular" physician. Although we do not require these modifiers be placed on the claim, any information that can help communicate involvement by another provider is considered helpful for processing.

Modifiers
Q5 - Service Furnished By Substitute Physician Reciprocal
Q6 - Service Furnished By A Locum Tenens Physician

https://www.bcbsal.org/providers/manuals/providerManual/useOfPMDProviderNumbers.cfm

6. **If the MD gives an inpatient status order as phone/verbal and is unable to sign off on that order prior to discharge, but his/her partner is available to sign off on this order prior to discharge, is this appropriate? The MD signing off isn't the MD that gave the order, so we want to make sure this isn't going to create an issue.**

   Response: We are okay with this scenario for regular business. It's also okay for Blue Advantage as long as the signing physician is in agreement with the order.

7. **For Blue Advantage patients, should qualitative immunohistochemistry (IHC) staining procedures be coded with the CPT codes 88342/88343 or the CMS codes G0461/G0462?**

   Response: The appropriate codes would be G0461/G0462 for Blue Advantage**.**

MR. HALEY: That's it for the questions. Now I'll hand it over to them for their presentation. Thank you.