Independence

PROVIDER BULLETIN
#25-2018

TO: Participating hospitals

FROM: Claim Operations

DATE: December 26, 2018

SUBJECT: Update: Clarification of documentation needed for claim submission; BCBSA high-dollar prepayment claims review policy

We are sending this bulletin to notify you that Independence Blue Cross (Independence) is retracting, in part, Bulletin #03-2018, which was sent on March 29, 2018, regarding the proposed clarification made to the definition of a "Clean Claim."

As a result, the definition of a "Clean Claim" will remain as set forth in the current version of the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers*.

However, as previously communicated on November 29, 2018 in a *Partners in Health Update*[SM] article, *BCBSA high-dollar prepayment claims review policy*, due to a new mandate from the Blue Cross and Blue Shield Association (BCBSA), **effective January 1, 2019,** the BCBSA will require all Blue plans to obtain an itemized hospital bill up front, in order to process certain BlueCard® claims for out-of-area members. Providers need to submit an itemized bill when they receive a code on an electronic remittance report (835) and/or paper Provider Remittance as identified on the next page.

In order to comply with the BCBSA mandate, when hospitals participating in Independence's network treat out-of-area members of another Blue plan, Independence will require the submission of an itemized bill from the participating hospital in order to process claims when each of the following criteria is met:

- Inpatient institutional (acute-care) claims; and
- Claims with an estimated allowed amount of $250,000 or greater; and
- Pricing methodologies except for the following claims pricing models that do not incorporate individual services or charges due to global pricing methodology:
  - Per-diem
  - Flat-fee case rate
  - DRG rate

Note: Claims for members in a Medicare Supplement/Medigap plan or traditional Medicaid are excluded.

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We encourage you to share this information with appropriate members of your staff.

If an itemized bill is not received for claims requiring special treatment in connection with this BCBSA mandate, then the claim may be denied. Providers need to submit an itemized bill when they receive a code on an electronic remittance report (835) and/or paper Provider Remittance as identified below.

Identifying a claim affected by this mandate

If you have a claim affected by this BCBSA mandate, you will see the following codes displayed on your electronic remittance report (835) and/or paper Provider Remittance with the following messages:

- **CARC 252** – An attachment/other documentation is required to adjudicate this claim/service.
- **RARC N26** – Missing itemized bill/statement

Invoice submission instructions

If your claim has been denied, you will need to submit an itemized bill. Please submit itemized bills via email at OOAHighDollarReview@ibx.com. *Note:* Use this e-mail address for itemized bill submissions only.

More information

If you have additional questions regarding a claim denied as a result of the BCBSA mandate, please email us at providerauditinquiries@ibx.com. Please include *BCBSA high-dollar prepayment claims* in the subject line.