Independence

PROVIDER BULLETIN
#23-2013

TO: Participating hospitals and ambulatory surgical centers

FROM: Contracting and Provider Networks

DATE: November 19, 2013

SUBJECT: Enforcing Industry Standards

As of November 1, 2013, we have begun transitioning our Independence Blue Cross (IBC) membership to a new operating platform. As a result of the transition, we will be enforcing industry standards for claims processed on the new platform (including Federal Employee Program [FEP] members and Host BlueCard® claims). If you have been submitting claims based on industry standards, as has been communicated to you in the past, you will have no issues with the topics noted in this bulletin. However, if you have not, please be advised that you will see an increase in rejections and/or claim denials for claims processed on the new platform.

Value codes and amounts

Both the proper value code(s), as defined by the National Uniform Billing Committee (NUBC), and the coinciding charge must be billed as it applies to the claim. The charge amount must be *greater than zero* when the value code is other than 02, 12, 13, 14, 15, 16, 41, 42, 43, 45, 47, or 80 – 83.

IBC will not contact facilities to obtain this additional information. If you submit a claim that does not follow this requirement, it will be rejected.

Non-specific codes

All non-specific codes must be submitted with the appropriate narrative description of the actual services rendered. Non-specific codes may include descriptor terms such as: Not Otherwise Classified (NOC); Unlisted; Unspecified; Other: Miscellaneous; Prescription Drug, Generic; or Prescription Drug, Brand Name. If you submit a claim that does not follow this requirement, it will be rejected.

Note: You must continue to submit a valid National Drug Code (NDC), as applicable, for prescription drugs in addition to supplying the appropriate narrative description.

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

Ambulatory Payment Classification (APC)

As stated in previous communications, all modifiers required in accordance with billing guidelines from the Centers for Medicare & Medicaid Services will be in effect. In order to receive the correct level of reimbursement, all claims submitted should contain the appropriate modifiers for the services rendered. If an APC service line is submitted without the proper modifier, the claim will be denied in its entirety. You will be required to resubmit the whole claim for further consideration.

For more information

For more information about our Business Transformation, please visit our dedicated site at *www.ibx.com/pnc/businesstransformation*. On this site, you will find a communication archive and Frequently Asked Questions (FAQ) document. If you still have questions after reviewing the FAQ, email us at *provider_communications@ibx.com*.