



**Independence  
Blue Cross**

**www.ibx.com**

# PARTNERS IN HEALTH UPDATE

July 2007

*Working Together For Quality Health Care*

## *Clinical Update Articles Now Appearing in Partners in Health Update*

In order to streamline our communications and better serve you, we are publishing all clinically-related articles in *Partners in Health Update*. The last issue of *Clinical Update* was the Spring 2007 edition; in the future, all articles previously included in *Clinical Update* will appear in *Partners in Health Update*.

This will allow you to receive all communications in one section on our website and eliminate the need to refer to multiple publications. Information regarding the daily administration of your practice, as well as disease-specific and detailed preventive health topics, will be found in *Partners in Health Update*.

Please email us at [provider\\_communications@ibx.com](mailto:provider_communications@ibx.com) with your questions or comments on how we can improve our communication efforts.

For articles specific to your area of interest, look for the appropriate icon:












-  Professional
-  Facility
-  Ancillary

## INSIDE THIS ISSUE







### NATIONAL PROVIDER IDENTIFIER (NPI)

-    • 10 Digits. Big Impact. The Power of NPI
-    • IBC NPI Contingency Plan

### BILLING

-    • Independence Administrators Begins Serving Members July 1
-    • Continuous Hospice Precertification
-    • IBC and Laboratory Corporation of America Create a Lab Test Diabetic Profile
-   • Claims Preprocessor Enhancements


### POLICY

-    • Clarification to the Nerve Conduction Studies (NCS) Policy #07.03.18a and Needle Electromyogram (EMG) Studies Policy #07.03.09b
-    • Treatment of Varicose Veins of the Lower Extremities #11.02.01e

### CREDENTIALING

-  • Drug Enforcement Administration (DEA) Registration Clarification for Individual Practitioners

### QUALITY MANAGEMENT

-    • Tips on How You Can Help Protect Your Patients' Health Care and Identity Information

### NAVINET<sup>SM</sup>

-    • New Enhancement to BlueExchange<sup>®</sup> Out-of-Area Transaction: Eligibility and Benefits Inquiry

### PREVENTIVE HEALTH

-   • Annual Connections<sup>SM</sup> Health Management Program Provider and Member Satisfaction Surveys
-   • Shared Decision-Making<sup>®</sup> Videos Prime Patients for Informed Discussions

### REMINDER

-   • New Nutrition Counseling Benefit Available to Commercial HMO, POS, and PPO Members

# 10 digits. BIG IMPACT.

## The Power of NPI



Share Your NPI Now to Avoid Potential Regulatory Penalties and Impact to Cash Flow

**Get It.** Get it **NOW** from the National Plan and Provider Enumeration System (NPPES).

- Get your NPI(s): a unique 10-digit identification number. We recommend you enumerate with your current corporate ID configuration.
- Get it now. Do not wait.
- Get it faster on the Web at <https://nppes.cms.hhs.gov>.

**Share It.** Share it **NOW** with us, billing companies, and clearinghouses. Failure to share your NPI may result in regulatory penalties and may impact cash flow.

- Share your NPI with us before you file your next claim.
- Share it with your colleagues who rely on your NPI to submit their claims.
- Share it with your billing service, vendor, or clearinghouse.

**Use It.** Use it **NOW** to identify yourself.

- Use it now along with your 10-digit legacy provider identifiers on your electronic and paper claims (if you have reported your NPI(s) to IBC).
- Use it now to facilitate accurate and streamlined processing of claims.
- Use it to be HIPAA-compliant.

### How to Obtain an NPI

NPPES is currently accepting applications for NPIs. Providers who have not yet obtained an NPI may apply for it in one of the following ways:

#### Electronic

- ▶ Complete the Web-based application online at <https://nppes.cms.hhs.gov>. It takes approximately 20 minutes to complete and is the most time-efficient method of obtaining an NPI.

#### Paper

- ▶ Providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator. The form will be available only upon request through the NPI Enumerator. Providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of the following ways:

- ▶ **Phone:** 1-800-465-3203 or TTY/TDD 1-800-692-2326
- ▶ **Email:** [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)
- ▶ **Mail:**  
NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059

All the information you need is available at [www.ibx.com/providers/npi](http://www.ibx.com/providers/npi)

Failure to prepare could result in a disruption in cash flow.  
Are you ready to use your NPI?

## IBC NPI Contingency Plan



### Background

In response to concerns over the health care industry's state of readiness for the May 23, 2007, National Provider Identifier (NPI) compliance date, the Centers for Medicare & Medicaid Services (CMS) announced that through May 23, 2008, they will not impose penalties on covered entities that deploy contingency plans to facilitate NPI compliance of their trading partners. CMS is encouraging health plans to assess the readiness of their provider communities and determine the need to implement contingency plans to maintain the processing of payments, while continuing to work toward compliance.

IBC has conducted sustained and targeted outreach to the provider community, requesting that all providers share their NPIs with us prior to the May 23, 2007, NPI compliance date. When providers share their NPIs with IBC, we are able to link the NPIs to existing data in our internal processing systems. We call this process "registering" NPIs with IBC. This is the only way to ensure that all existing provider data in the IBC claims (and other) systems are properly linked to newly assigned NPIs. To mitigate any potential impact in a provider's cash flow, we have requested that providers register their NPIs with us *prior to submitting an NPI claim*.

Because of providers responding favorably to IBC's requests, we have made demonstrable progress to date in receiving a significant percentage of provider NPIs. Despite this progress, less than 100 percent of our participating (and other) providers and trading partners have registered their NPIs with us. In order to allow additional time for providers to register their NPIs with us, IBC is deploying the contingency plan outlined below, which is in alignment with CMS' guidance.

### IBC's Contingency Plan: Dual Use

Currently, IBC has the ability to accept claims with an NPI as the primary identifier if the provider has registered their NPI with us.

However, providers must register their NPI with IBC prior to submitting NPI-only claims. Beginning July 1, 2007, NPI-only claims will reject if the provider has not registered their NPI with us. To avoid any potential business disruption for those providers who have not registered their NPI with IBC, we have recommended a dual use strategy for claims submissions.

The dual use strategy allows providers to submit all electronic and paper claims with NPIs and 10-digit legacy provider identifiers (IBC-assigned IDs providers use to identify themselves as an IBC participating health care provider). We will continue this dual use strategy until further notice while continuing our provider outreach and testing efforts. If providers have registered their NPI with IBC or submitted an NPI with a CMS certification, they may continue to submit claims with their NPI and 10-digit legacy identifier, consistent with our dual use strategy, until further notice.

Our dual use strategy is intended to ensure that IBC is NPI compliant, but in a manner that maintains operations, recognizes providers' varying states of readiness, and avoids unnecessary disruption in their cash flow.

IBC will assess provider readiness and the continued necessity of its dual use strategy periodically. Once IBC determines that a sufficient percentage of providers have registered their NPIs with us and are submitting their NPIs on claims, we will end the contingency plan and begin rejecting claims without an NPI as the primary identifier. We will give 60 days prior notice to providers, their clearinghouses, and vendors before implementing this course of action. However, after May 23, 2008, only the NPI will be accepted on inbound or outbound transactions.

More information about IBC's NPI Dual Use Claims Submission, including electronic and paper claim submission instructions and relevant FAQs, is available at [www.ibx.com/providers/npi](http://www.ibx.com/providers/npi).

*continued on page 4*

# NATIONAL PROVIDER IDENTIFIER (NPI)

## IBC NPI Contingency Plan (*continued*)

### Steps IBC has Taken to Assist Providers with NPI Compliance

IBC has assisted providers with their NPI compliance efforts by establishing a comprehensive targeted communication and outreach campaign to the provider network.

The outreach campaign focuses on the following goals:

- 100 percent receipt of NPIs from our participating providers
- Continued education of providers on NPI enumeration, registration, and compliance
- Increased provider readiness/compliance

To further assist providers with NPI-related questions, IBC has increased NPI awareness internally with employee training modules and various print and electronic communications.

### Continued Steps IBC Will Take to Assist Providers

IBC will continue to assist providers with their NPI compliance efforts by following an established plan, which includes:

- Continued targeted communications and provider outreach to increase NPI registration
- Continued internal awareness and education through employee training modules and instructor-led training sessions
- Ongoing monitoring and assessment of provider network readiness

For more information regarding NPI, including instructions for obtaining an NPI or registering NPIs with IBC, please visit [www.ibx.com/providers/npi](http://www.ibx.com/providers/npi).

You can find detailed IBC NPI Dual Use Claims Submission instructions in the following locations:

- **837P and 837I Companion Guides.** The 837P Companion Guide and 837I Companion Guide provide instructions for submitting dual use claims for electronic claims submissions.

The companion guides are available online at [www.ibx.com/providers/self\\_service\\_tools/edi/forms.html](http://www.ibx.com/providers/self_service_tools/edi/forms.html). These companion guides should be used as a supplement to the HIPAA guidelines for claim submission.

- **Revised CMS-1500 and New UB-04 Claim Forms and Instructions.** These reference tools were published as enclosures with the October 2006 and February 2007 editions of *Partners in Health Update*. They provide instructions for submitting dual use claims for paper submissions. These reference tools are also available at [www.ibx.com/providers/npi/forms.html](http://www.ibx.com/providers/npi/forms.html).

### Questions Regarding NPI Dual Use Claims Submission

Please contact your Network Coordinator with any questions regarding IBC NPI Dual Use Claims Submission.

If you have not yet obtained your NPI(s) and reported them to us, please refer to the How to Obtain an NPI sidebar, or visit [www.ibx.com/providers/npi](http://www.ibx.com/providers/npi).

You may also visit the following websites for additional information:

#### IBC Provider NPI website

[www.ibx.com/providers/npi](http://www.ibx.com/providers/npi)

Contains NPI background, FAQs, submission instructions, Web links, and other information.

#### CMS Main NPI website

[www.cms.hhs.gov/NationalProvIdentStand/](http://www.cms.hhs.gov/NationalProvIdentStand/)

Contains NPI Final Rule, FAQs, fact sheets, tip sheets, NPI Viewlet, Medicare MedLearn articles, and enumeration statistics.

#### NPI Enumerator website

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Main site to enter an NPI application.

#### WEDI NPI Outreach Initiative

[www.wedi.org/npioi/index.shtml](http://www.wedi.org/npioi/index.shtml)

NPI Resource Center with information resources, Industry readiness assessment survey, etc.

## Independence Administrators Begins Serving Members July 1



**Effective July 1, 2007**, Independence Administrators, a new third-party administrator from IBC, begins providing services to self-funded health plans based in the Greater Philadelphia area.

Here is what you will see when a patient presents an Independence Administrators ID card for services beginning July 1:

- Claims submission address:  
P.O. Box 1010, Horsham, PA 19044
- Payer ID number for electronic claims submission:  
TA720
- Toll-free call center phone number:  
[1-888-356-7899](tel:1-888-356-7899)
- Precertification phone number:  
[1-888-234-2393](tel:1-888-234-2393)

For information or inquiries, NaviNet<sup>SM</sup> for Independence Administrators Plan Central becomes available in July. The new toll-free call center phone number and precertification number are ready for calls starting July 1.



**Independence  
Administrators**

## Continuous Hospice Precertification



**Effective immediately**, precertification is no longer required for continuous hospice in the home. The affected revenue code is *652 Hospice Continuous Home Care*.

Please keep timely and appropriate physician orders on file, as they are required for all hospice services. IBC may request these orders at any time. For services requiring precertification, please contact the Health Resource Center at [1-800-227-3116](tel:1-800-227-3116) or at [215-241-2100](tel:215-241-2100).

*Please note:* The reimbursement rate for hospice services is all-inclusive; therefore, no additional services (such as durable medical equipment, private duty nursing, or home infusion services) will be authorized while the member is on hospice.

*Inpatient hospice and all hospice services for Federal Employee Program (FEP) members will still require precertification.*

### IBC and Laboratory Corporation of America Create a Lab Test Diabetic Profile



We recently worked with the Laboratory Corporation of America (LabCorp) to build a Diabetic Profile — the profile includes a series of tests that providers can order through LabCorp. The Diabetic Profile will make it easier to order the appropriate tests required to manage and monitor your diabetic patients. The Diabetic Profile is now available.

The custom panel number for the Diabetic Profile is 339659.

The following tests are included in this panel:

- Hemoglobin A1c (LabCorp test code: 001453)
- Fasting plasma glucose (LabCorp test code: 001032)
- Lipid panel (LabCorp test code: 235010)
- Microalbumin (LabCorp test code: 149997)

You may contact LabCorp's Raritan Laboratory Customer Service area at [1-800-631-5250](tel:1-800-631-5250).

*Reminder:* Patients with diabetes can get support through our Connections<sup>SM</sup> Health Management Program. To refer a diabetic member for Health Coaching, call the Connections Provider Support Line at [1-866-866-4694](tel:1-866-866-4694).

*Note:* This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

### Claims Preprocessor Enhancements



We recently enhanced our Claims Preprocessing Worksheet that was originally mailed with the July 2006 issue of *Partners in Health Update*. Included with this publication is the revised worksheet that highlights rules that will be applied to claims and a comment on how to remedy rejected claims. This will help you to determine why a claim was rejected and provide a basis for resubmitting a clean claim.

This worksheet may be updated on a regular basis to reflect new error codes and claim resolution instructions.

It is intended to provide guidance on current billing submission errors we have encountered. For additional assistance contact the eBusiness Operations Production Support Service Desk at [215-241-2305](tel:215-241-2305).

## Clarification to the Nerve Conduction Studies (NCS) Policy #07.03.18a and Needle Electromyelogram (EMG) Studies Policy #07.03.09b



**Effective August 1, 2007**, for dates of service on or after August 1, 2007, NCSs and EMGs will be covered and considered eligible for reimbursement when these studies are performed by professional health care providers who are properly trained, licensed, and acting within their state's board-defined scope of practice. Documentation of the performing provider's qualifications must be made available upon request. Regardless of the performing provider, only properly trained physicians should interpret the EMG and NCS results.

All medical necessity requirements listed in the above-noted policies must also be met in order for these services to be covered and considered eligible for reimbursement.

- Only physicians are eligible to receive reimbursement for the professional component of EMGs and NCSs. Physicians may also receive reimbursement for the technical component if they performed that service.
- Non-physician professional providers are only eligible to receive reimbursement for the technical component of EMGs and NCSs.

*Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.*

## Treatment of Varicose Veins of the Lower Extremities #11.02.01e



The medical policy on the Treatment of Varicose Veins of the Lower Extremities #11.02.01e has been revised. The updated version of this policy now states that injecting varicose veins of the lower extremities with sclerosing solution is appropriate *for varicosities greater than 3 mm*. Previous versions of

this policy stated that the varicosities should not be greater than 4 mm.

*Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.*

### Drug Enforcement Administration (DEA) Registration Clarification for Individual Practitioners



The Drug Enforcement Administration (DEA) recently amended its registration regulations to make it clear that when an individual practitioner practices in more than one state, he or she must obtain a separate DEA registration for each state.

A detailed explanation of this final rule can be found at the Office of Diversion Control website: [www.dea diversion.usdoj.gov/fed\\_regstrules/2006/fr1201.htm](http://www.dea diversion.usdoj.gov/fed_regstrules/2006/fr1201.htm).

The National Committee for Quality Assurance (NCQA) advised us that an organization must verify DEA certification in all states where the practitioner is providing services for the organization.

#### What does this mean?

In accordance with the DEA rule and NCQA requirements, as part of the credentialing or recredentialing process, we will require a DEA registration for each state in which the practitioner provides services to our members. *Please note:* This only applies to practitioners whose scope of practice requires a DEA certificate.

## Tips on How You Can Help Protect Your Patients' Health Care and Identity Information



Maintaining the security of health care and identifying information is important to you, to your patients, our members, and to IBC. In order to preserve our members personal and health care information that is shared with your office, (and among other patients in the waiting room), we would like to offer a few suggestions on simple but beneficial ways your office can help protect our members' privacy.

- Be mindful of your staff's location and who is in earshot and whether or not someone is standing too close.
- Shred unwanted patient data daily.
- Angle your computer screens so they are not visible to probing eyes.
- Furnish pads and pencils for your patients to write their identifying information on. When your office staff finishes with the use of the data they should immediately shred the paper.

- Obtain shredder receptacles of a different color from your regular trash and instruct your staff in their use.
- Discuss a patient's situation in a location where patient privacy is assured.
- Keep patient data out of public view.

Our Corporate and Financial Investigations Department proactively investigates allegations of health care and identity data theft or loss as well as misuse of benefits by those other than the authorized members. Our hotline number to report health care fraud is [1-866-282-2707](tel:1-866-282-2707). Please keep in mind that you share in the responsibility of protecting patient information. By following the suggestions mentioned above, you will become more aware of potential loss situations and thereby reduce your risk of health care and identity theft.

# New Enhancement to BlueExchange<sup>®</sup> Out-of-Area Transaction: Eligibility and Benefits Inquiry



The BlueExchange<sup>®</sup> out-of-area transaction has been enhanced for the Eligibility and Benefits Inquiry. This new enhancement will make it easier to research specific benefits by choosing the appropriate Service Type in the Eligibility and Benefits Inquiry screen. Once the search is complete, the information for the specific type of service requested will display.

If you have any questions or if you need additional information, please refer to the User Guides under Customer Service, or contact NaviMedix<sup>SM</sup> Customer Care at 1-888-482-8057.

Below is a sample of the new BlueExchange out-of-area enhancement:

**BlueExchange<sup>®</sup> Eligibility and Benefits Inquiry**

The BlueExchange Inquiry transaction allows users to make eligibility inquiries on out-of-area members. When entering the Subscriber/Patient ID, please include the Alpha Prefix. The patient's health plan may take up to 60 seconds to respond. If you do not receive a response, please follow the instructions on the back of the patient's ID card to contact their Plan.

Provider: Clinical Associates

Subscriber/Patient ID: YFX98765432101 Patient is: Dependent

Patient Last Name: SAMPLE Patient First Name: LOUIS

Patient Gender: MALE Patient DOB: 01/14/1943

Date of Service: 06/19/2007

Service Type: General Benefits

Patient Name: SAMPLE, LOUIS

---

**BlueExchange<sup>®</sup> Eligibility and Benefits Detail**

Note: Member information that has been correct will be displayed in blue.

Member Name: SAMPLE, LOUIS Member ID: YFX98765432101  
 Member Address: 123 Maple Street Member DOB: 01/14/1943  
 SCRANTON, PA 18510 Member Gender: Male

Relationship To Insured: Self

BlueExchange Trace Number: BX270000001341

Member Group Number: 004015680  
 Member Group Name: 123 METRO CREDIT UNION  
 Enrollment: 06/19/2005

**Member/Patient Eligibility and Benefit Details**

Eligibility Status: Active Coverage  
 Plan Coverage Description: Indemnity  
 Insurance Type Description: Point of Service (POS)  
 Eligibility Begin: 06/19/2005  
 Eligibility End: 06/19/2009  
 Primary Care Provider: 12/25/2006  
 Coverage: Individual

**Member/Patient Additional Information**

Primary Care Provider : SMITH, JOE, MD  
 Service Provider Number : 3333344444  
 Telephone Number: 215-444-5566

## Annual Connections<sup>SM</sup> Health Management Program Provider and Member Satisfaction Surveys



### Provider Satisfaction Survey Results

The third annual provider satisfaction survey for the Connections<sup>SM</sup> Health Management Program was conducted by an independent research company in the fourth quarter of 2006. More than 2,700 surveys were mailed or hand-delivered by Provider Service Specialists (PSSs). The survey found awareness of the program was high, and of the 5% of providers who responded:

- Almost 40% indicated patients had discussed the Connections Health Management Program with them.
- More than 85% indicated the program improved communication with their patients.
- 59% found the SMART<sup>®</sup> Registry helpful.
- 61% found the PSSs' support helpful.
- More than half indicated these programs provided a more positive image of IBC.

Overall, 64% of providers responded that the Connections Health Management Program was helpful for their patients with chronic conditions.

### Member Satisfaction Survey Results

The 2006 member satisfaction survey was conducted by phone in the fourth quarter of 2006. More than 830 IBC members were contacted and surveyed. Members called included those with and without chronic conditions, as well as members who had and had not had contact with a Health Coach in the past 6 to 12 months.

- 96% of respondents with a chronic condition and 65% of those without a chronic condition said they were able to follow their Health Coach's guidance.
- More than 70% of respondents with and without a chronic condition said speaking with a Health Coach improved their ability to talk to their doctor or health care provider.
- 90% of members surveyed with a chronic condition and 95% of members surveyed without a chronic condition stated they would recommend the Connections Program to a friend or family member.
- More than 85% of members surveyed with and without a chronic condition stated they felt better about IBC because it offers the Connections Program.

For more information on the Connections Health Management Program, please call the Connections Provider Support Line at [1-866-866-4694](tel:1-866-866-4694).

# Shared Decision-Making® Videos Prime Patients for Informed Discussions



As medicine evolves and becomes more nuanced, physicians are increasingly faced with patients whose conditions can be reasonably treated in more than one way. This phenomenon has the advantage of offering patients choices, but it also means that physicians have to spend more time explaining treatment options and outlining their potential risks and benefits. The Connections<sup>SM</sup> Health Management Program is working to make that process easier by offering members round-the-clock telephonic access to Health Coaches and by making a library of Shared Decision-Making® videos available to both members and their physician.

Connections Health Coaches are specially trained health care professionals, such as nurses, dietitians, and respiratory therapists. They provide your patients with information about their “preference-sensitive” conditions and present unbiased views of treatment options. Health Coaches help patients identify and consider personal values and preferences and encourage patients to work closely with their physicians in making treatment choices. When appropriate, Health Coaches can also send patients printed materials and Shared Decision-Making® videos that provide engaging, unbiased information about treatment and screening options.

As the name implies, Shared Decision-Making® videos are designed to encourage patient participation in the medical decision-making process. These videos and accompanying booklets help to provide patients with the information they need to have a productive discussion with their physicians. The information presented is evidence-based and independently vetted by the Foundation for Informed Medical Decision Making, a non-profit organization dedicated to improving the quality of medical decisions.

A good example is the Shared Decision-Making® video *Treatment Choices for Uterine Fibroids*. This video, and the booklet that comes with it, describes

the various treatment options for fibroids, including:

- “watchful waiting”
- medical management of fibroid symptoms with NSAIDs, oral contraceptives, and medicated IUDs
- nonsurgical interventions, such as uterine artery embolization and focused ultrasound ablation
- myomectomy
- hysterectomy

After explaining each treatment option, the program lists the probabilities of different potential treatment outcomes. The section on myomectomy, for instance, tells women that the procedure relieves symptoms in about 80 percent of cases and usually preserves fertility but that fibroids reappear in one out of four women.

With this information in hand and the support of a Health Coach, it is easier for women to discuss with their doctors how they feel about the treatment options based on their specific clinical situation as well as their values and priorities. The goal is to produce more informed, collaborative decisions and greater patient satisfaction.

The library of more than 20 Shared Decision-Making® videos covers topics ranging from herniated discs to depression. The information presented in some videos is also available in Web modules. To find out more about the video library and other Shared Decision-Making® services, contact the Connections Health Management Program Provider Support Line at 1-866-866-4694. A Connections Provider Service Specialist will return your call within two business days. A list of available videos can be found in the Shared Decision-Making® brochure located at [www.ibx.com/providers/resources/connections.html](http://www.ibx.com/providers/resources/connections.html).

*Note:* DVDs are also available.

*Shared Decision-Making® is a registered trademark of the Foundation for Information Medical Decision Making. Used with permission.*

*Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.*

## New Nutrition Counseling Benefit Available to Commercial HMO, POS, and PPO Members



We are taking a leadership role in the Philadelphia region by introducing a new nutrition counseling benefit for our members. **Effective July 1, 2007**, registered dietitians and physicians may provide up to six nutrition counseling visits per year to adults and children covered by commercial HMO, POS, and PPO plans. PCPs may bill for nutrition counseling visits above capitation.

The purpose of the six nutrition counseling visits is to support our members in establishing good eating habits that will contribute to a healthier lifestyle. We recognize the impact of a well-balanced diet on good health, and we are proud to offer the nutrition counseling visits as a core benefit to our already comprehensive benefits plans.

A nutrition counseling visit could include:

- An assessment of dietary habits
- The use of measurement tools, such as the Body Mass Index, to assess risk
- Development of a strategy and goals to achieve the dietary change

- Ongoing support to maintain dietary changes and reevaluate goals
- Guidance toward an appropriate exercise program

Members pay nothing out of pocket when a participating physician or registered dietitian provides the nutrition counseling. No copayments will be due from HMO, POS, or PPO members receiving services from participating physicians or dietitians. Participating registered dietitians will be listed on NaviNet<sup>SM</sup> and in our online directories. A referral is required for HMO members seeking services from a registered dietitian or a physician. PPO and POS members must satisfy any deductibles or coinsurance when utilizing out-of-network and self-referred benefits.

### Billing

The following codes should be used when billing for nutrition counseling. (The specifics of the clinical scenario will dictate the appropriate code. Documentation to support the use of the codes submitted should be made available to us upon request.)

Code	Narrative
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment, and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
S9449	Weight management classes, nonphysician provider, per session
S9452	Nutrition classes, nonphysician provider, per session
S9470	Nutritional counseling, dietitian visit

*continued on page 14*

## REMINDER

### New Nutrition Counseling Benefit Available to Commercial HMO, POS, and PPO Members *(continued)*

In addition to the nutrition counseling visit codes listed on the previous page, the following diagnosis codes should be used to report the Body Mass Index for adult members who are utilizing the nutrition counseling benefit. Based on official guidelines for coding and reporting, these secondary codes should

not be listed in the first position on a claim or reported as the principal diagnosis. Reporting these additional codes will help us determine member eligibility for additional interventions and/or outreach programs.

Diagnosis Code	Description
V85.0	Body Mass Index less than 19, adult
V85.1	Body Mass Index between 19-24, adult
V85.21	Body Mass Index 25.0-25.9, adult
V85.22	Body Mass Index 26.0-26.9, adult
V85.23	Body Mass Index 27.0-27.9, adult
V85.24	Body Mass Index 28.0-28.9, adult
V85.25	Body Mass Index 29.0-29.9, adult
V85.30	Body Mass Index 30.0-30.9, adult
V85.31	Body Mass Index 31.0-31.9, adult
V85.32	Body Mass Index 32.0-32.9, adult
V85.33	Body Mass Index 33.0-33.9, adult
V85.34	Body Mass Index 34.0-34.9, adult
V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.4	Body Mass Index 40 and over, adult
V85.51	Body Mass Index, pediatric, less than 5th percentile for age
V85.52	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age
V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age

## New Nutrition Counseling Benefit Available to Commercial HMO, POS, and PPO Members *(continued)*

### Additional Programs

Our long-standing commitment to helping our members exercise healthy eating habits goes beyond our new nutrition counseling benefit. Members can also take advantage of our Healthy Lifestyles<sup>SM</sup> programs, which include reimbursements for fitness center fees and approved weight loss programs as well as discounts on vitamins and nutritional supplements. Our Healthy Lifestyles programs are designed to encourage healthy behavior. Members eligible for our Connections<sup>SM</sup> programs who may be considering weight loss surgery can call the Connections Health Management Program at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE) to receive Health Coaching and a free Shared Decision-Making<sup>®</sup> video/DVD on bariatric surgery treatment options. If a member has a question regarding eligibility, he or she may call the Member Services number listed on his or her ID card.

We strive to help those at risk for obesity lead healthier lives and educate all members about how to maintain a healthy weight. For more information on the evaluation and treatment of overweight patients, please see our Clinical Practice Guidelines on obesity at [www.ibx.com/providers/policies\\_guidelines/clinical\\_guidelines/index.html](http://www.ibx.com/providers/policies_guidelines/clinical_guidelines/index.html). PCPs are encouraged to talk to their patients about this benefit, refer them to a registered dietitian, or direct them to call Member Services or visit [www.ibxpress.com](http://www.ibxpress.com).

If you have additional questions regarding the new nutrition counseling benefit, please contact Provider Services.

*Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.*

*Codes listed previously are subject to change due to quarterly and annual HCPCS/CPT and revenue code updates. The codes listed are current as of the date of this publication.*



*Partners in Health Update* is a publication of the Provider Communications department for the exchange of information and ideas among the IBC Provider community. Suggestions are welcome.

**CONTACT INFORMATION:**

Caroline Crispino  
*Managing Editor*

Charleen Baselice  
*Production Coordinator*

**Provider Communications**  
**Independence Blue Cross**  
**1901 Market Street**  
**35th Floor**  
**Philadelphia, PA 19103**  
*provider\_communications@ibx.com*

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield—Independent licensees of the Blue Cross and Blue Shield Association.

© The Blue Cross and Blue Shield words and symbols, and BlueExchange are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, Indemnity, etc.), and/or employer groups. Providers should call Provider Services, listed at right, for the member's applicable benefit information. Members should be instructed to call the number on the back of their identification card.

Not all benefit plans use Magellan Behavioral Health, Inc. to administer behavioral health benefits. Please check the back of the member's ID card for the telephone number to contact for behavioral health services, if applicable.

The third-party websites mentioned in this publication are maintained by organizations over which IBC exercises no control, and accordingly, IBC disclaims any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised in these third-party sites. URLs presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

CPT® (Current Procedural Terminology) is a copyright of the American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a registered trademark of the American Medical Association.

Investors in NaviMedix®, Inc. include an affiliate of IBC, which has a minority ownership interest in NaviMedix®, Inc.



# IMPORTANT RESOURCES

View our online provider directories at [www.ibx.com](http://www.ibx.com)

**CARE MANAGEMENT AND COORDINATION**

Case Management 215-567-3570  
1-800-313-8628\*

Baby BluePrints® 215-241-2198  
1-800-598-BABY (2229)\*

**CONNECTIONS<sup>SM</sup> HEALTH MANAGEMENT PROGRAMS**

Connections<sup>SM</sup> Health Management Program Provider Support Line 1-866-866-4694

Connections<sup>SM</sup> Kidney Program 1-866-303-4CKP (4257)

Connections<sup>SM</sup> AccordantCare<sup>TM</sup> Program 1-866-398-8761

**CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT**

Anti-Fraud and Corporate Compliance Hotline 1-866-282-2707  
[www.ibx.com/anti-fraud](http://www.ibx.com/anti-fraud)

**CREDENTIALING VIOLATION HOTLINE**

215-988-6534  
[www.ibx.com/credentials](http://www.ibx.com/credentials)

**eBUSINESS**

Help Desk 215-241-2305

eBusiness Provider Hotline 215-640-7410

**FutureScripts<sup>TM</sup>**

Prescription Drug Authorization 1-888-678-7012  
Toll Free Fax 1-888-671-5285

Direct Ship Injectable 1-888-678-7012  
Fax 215-761-9165

Blood Glucose Meter Hotline 1-888-494-8213 (option 2)

**FutureScripts<sup>TM</sup> Secure**

Medicare Part D 1-888-678-7015

**HEALTH RESOURCE CENTER**

Healthy Lifestyles<sup>SM</sup> 215-241-3367  
1-800-275-2583\*

Precertification 215-241-2100  
1-800-227-3116\*

**PROVIDER ELECTRONIC DATA INTERCHANGE SERVICES WEB PAGE**

[www.ibx.com/edi](http://www.ibx.com/edi)

**PROVIDER INFORMATION and TOOLS WEB PAGE**

[www.ibx.com/providers](http://www.ibx.com/providers)

**PROVIDER MEDICAL POLICY WEB PAGE**

[www.ibx.com/medpolicy](http://www.ibx.com/medpolicy)

**PROVIDER PHARMACY WEB PAGE**

[www.ibx.com/provider\\_rx](http://www.ibx.com/provider_rx)

**PROVIDER SERVICES (Policies/Procedures/Claims)**

HMO 215-567-3590  
1-800-227-3119\*

PPO 215-567-3694  
1-800-332-2566\*

**PROVIDER SUPPLY LINE**

1-800-858-4728

\* Outside 215 area code



**Independence  
Blue Cross**

The Claims Preprocessing Edits Claims Resolution Document was published along with this edition of *Partners in Health Update*.

The file has been added to this PDF for your convenience.

---

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3001	Missing/Invalid Procedure Code	P0001a	Procedure Code Validation	P0001a Procedure code ___ on service line ___ is invalid. Please correct and resubmit.	A3	122	A3	454	2400.SV101-2	The procedure code submitted on the claim was invalid. The provider must resubmit the claim with a valid procedure code.
3001	Missing/Invalid Procedure Code	P0001b	Procedure Code Validation	P0001b Procedure code ___ on service line ___ is invalid for date of service provided. Please correct and resubmit.	A3	122	A3	454	2400.SV101-2 and date billed in 2400.DTP03 when DTP01 = 472 (Service Line Date) if DTP02 = RD8 (Range of Dates) use first 8 bytes must fall between the procedure code effective and termination dates.	The procedure code submitted on the claim was not effective for the service line date on the claim. The provider must resubmit the claim with a valid procedure code that is within the effective and termination date of the procedure code.
3134	Missing/Invalid HCPCS Modifier Code	P0002a	Modifier Code Validation	P0002a Modifier code ___ on service line ___ is invalid. Please correct and resubmit.	A3	122	A3	453	2400.SV101-3, SV101-4, SV101-5, or SV101-6	The procedure code modifier submitted on the claim was invalid. The provider must resubmit the claim with a valid procedure code modifier.
3134	Missing/Invalid HCPCS Modifier Code	P0002b	Modifier Code Validation	P0002b Modifier code ___ on service line ___ is invalid for date of service provided. Please correct and resubmit.	A3	122	A3	453	2400.SV101-3, SV101-4, SV101-5, or SV101-6 and date billed in 2400.DTP03 when DTP01 = 472 (Service Line Date) if DTP02 = RD8 (Range of Dates) use first 8 bytes must fall between the modifier code effective and termination dates.	The procedure code modifier submitted on the claim was not effective for the service line date on the claim. The provider must resubmit the claim with a valid procedure code modifier that is within the effective and termination date of the procedure code modifier.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
N/A	N/A	P0003	Procedure/Modifier Code Validation	P0003 Modifier ___ on service line ___ is not valid when billed with procedure code ___; valid modifiers for this procedure are ___. Please correct and resubmit.	A3	122	A3	453	2400.SV101-2 and SV101-3, SV101-4, SV101-5, or SV101-6	The procedure code modifier submitted on the claim can not be billed with the procedure code. The provider must resubmit the claim with a procedure code modifier that is valid with the procedure code submitted on the claim.
3008	Missing/Invalid Diagnosis code	P0004a	Diagnosis Code Validation	P0004a Diagnosis code ___ is missing or invalid. Please correct and resubmit.	A3	122	A3	255	2300. HI01-2 when HI01-1 = BK and 2300. HI02-2 – HI08-2 when HI02-1 – HI08-1 = BF	The diagnosis code submitted on the claim was invalid. The provider must resubmit the claim with a valid diagnosis code.
3008	Missing/Invalid Diagnosis code	P0004b	Diagnosis Code Validation	P0004b Diagnosis code ___ is missing or invalid ___ for date of service provided. Please correct and resubmit.	A3	122	A3	255	2300. HI01-2 when HI01-1 = BK and 2300. HI02-2 – HI08-2 when HI02-1 – HI08-1 = BF and use earliest date billed in 2400. DTP03 when DTP01 = 472 (Service Line Date) if DTP02 = RD8 (Range of Dates) use first 8 bytes must fall between the diagnosis code effective and termination dates.	The diagnosis code submitted on the claim was not effective for the service line date on the claim. The provider must resubmit the claim with a valid diagnosis code that is within the effective and termination date of the diagnosis code.
N/A	N/A	P0005	Service Line Charges Validation	P0005 Charges ___ on service line ___ exceeds \$99,999.99. Please correct and resubmit.	A3	122	A3	178	2400.SV102	The service line charge exceeds \$99,999.99. The provider must resubmit the claim and split the charges into 2 service lines.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
P12	Billing Provider Tax ID Number Required	P0006	Billing Provider Tax ID Validation	P0006 The billing provider tax ID ____ you submitted is not on file. Please correct and resubmit a valid billing provider tax ID.	A3	122	A3	128	2010AA.NM109 when 2010AA.NM108 equals 24 or 34 or 2010AA.REF02 when 2010AA.REF01 equals EI or SY	The billing provider tax ID number submitted on the claim is invalid. The provider must resubmit the claim using a valid tax ID number.
P0006	Billing Provider Tax ID Validation									
P5{DC}	Billing Provider Number must be 10 digits	P0007a	Billing Provider Number must be 10 digits	P0007a The billing provider ID ____ you submitted is not a 10 digit number. Please correct and resubmit with your 10 digit billing provider ID.	A3	122	A3	153	2010AA.REF02 when REF01 = 1A or 1B	The billing provider ID submitted on the claim was not equal to 10 digits. The provider must resubmit the claim with a valid 10-digit corporate ID number. This edit is only applicable to Keystone and Ancillary Facility claims.
P0007	Billing Provider Number must be 10 digits									
P5{DC}	Billing Provider Number must be 10 digits	P0007b	Billing Provider Number not valid format	P0007b The billing provider ID ____ you submitted is not valid. Please correct and resubmit a valid billing provider ID.	A3	122	A3	153	2010AA.REF02 when REF01 = 1A or 1B	The billing provider ID submitted on the claim was not the valid format. The provider must resubmit the claim with a valid provider ID. This edit is applicable only to Personal Choice and PC65.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
N/A	N/A	P0008a	Billing Provider Number Validation	P0008a Billing provider NPI _____ you submitted is not valid. Either the number submitted is not on file or the three-digit office location suffix is incorrect. Please correct and resubmit.	A3	122	A3	562	2010AA.NM109 when 2010AA.NM108 equals XX	The billing provider NPI submitted on the claim was not valid. The provider must resubmit the claim with a valid 10-digit corporate ID number for Keystone and Ancillary Facility claims or the PBS number for PA PPO. We will also accept the 10 digit corporate ID on PA PPO.
P6{DC}	Billing Provider Number Invalid	P0008b	Billing Provider Number Validation	P0008b Billing provider ID _____ you submitted is not valid. Either the number submitted is not on file or the three-digit office location suffix is incorrect. Please correct and resubmit.	A3	122	A3	153	2010AA.REF02 when REF01 = 1A or 1B	The billing provider NPI submitted on the claim was not valid. The provider must resubmit the claim with a valid 10-digit corporate ID number for Keystone and Ancillary Facility claims or the PBS number for PA PPO. We will also accept the 10-digit corporate ID on PA PPO.
P0008	Billing Provider Number Validation									
C2{DC}	Rendering Provider Number required	P0009	Rendering Provider Number Required	P0009 Rendering provider ID _____ on service line _____ is required and was not received. Please correct and resubmit.	A3	122	A3	153	2310B.REF or 2420A.REF segment must exist	The rendering provider ID was not submitted on the claim. The provider must resubmit the claim with a valid 10-digit corporate ID number for Keystone and Ancillary Facility claims or the PBS number for PA PPO. We will also accept the 10-digit corporate ID on PA PPO.
P0009	Rendering Provider Number required									

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
P7{DC}	Rendering Provider Number must be 10 digits	P0010a	Individual Provider Number must be 10 digits	P0010a Rendering provider ID ____ you submitted is not a 10 digit number. Please correct and resubmit with your 10 digit rendering provider ID.	A3	122	A3	153	2310B.REF02 or 2420A. REF02 when REF01 = 1B	The rendering provider ID submitted on the claim was not equal to 10 digits. The provider must resubmit with claim with a valid 10-digit corporate ID number for Keystone and Ancillary Facility claims or the PBS number for PA PPO. We will also accept the 10-digit corporate ID on PA PPO.
P0010	Rendering Provider Number must be 10 digits									
P7{DC}	Rendering Provider Number must be 10 digits	P0010b	Rendering Provider Number not valid format	P0010b Rendering provider ID ____ not valid format. Please correct and resubmit a valid individual provider ID.	A3	122	A3	153	2310B.REF02 or 2420A. REF02 when REF01 = 1B	The rendering provider submitted on the claim was not the valid format. The provider must resubmit the claim with a valid provider ID. This edit is only applicable to PA PPO.
N/A	N/A	P0011	Rendering Provider Number Validation	P0011a Rendering provider NPI ____ you submitted is not on file. Please correct and resubmit a valid rendering provider ID.	A3	122	A3	153	2310B or 2420A NM109 when NM108 equals XX	The rendering provider ID submitted on the claim was not valid. The provider must resubmit the claim with a valid 10-digit corporate ID number for Keystone and Ancillary Facility claims or the PBS number for PA PPO. We will also accept the 10-digit corporate ID on PA PPO claims.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
P8{DC}	Rendering Provider Number Invalid	P0011	Rendering Provider Number Validation	P0011b Rendering provider ID _____ you submitted is not on file. Please correct and resubmit a valid rendering provider ID.	A3	122	A3	153	2310B.REF02 or 2420A.REF02 when REF01 = 1B	The rendering provider ID submitted on the claim was not valid. The provider must resubmit the claim with a valid 10-digit corporate ID number for Keystone and Ancillary Facility claims or the PBS number for PA PPO. We will also accept the 10-digit corporate ID on PA PPO claims.
P0011	Rendering Provider Number Validation									
F04{DC}	Tax ID does not match Billing Provider Number	P0012	Billing Provider Number/Tax ID Validation	P0012 Billing Provider Number _____ - Tax ID _____ combination is NOT valid. Please correct and resubmit.	A3	122	A3	153	Billing Provider Number - 2010AA.REF02 when REF01 = 1A or 1B  Tax ID - 2010AA.NM109 when 2010AA.NM108 equal 24 or 34 or 2010AA.REF02 when 2010AA.REF01 equals EI or SY	The rendering provider ID does not match the billing provider tax ID submitted on the claim. The provider must resubmit the claim using a billing provider ID that matches the tax ID.
P0012	Billing Provider Number/Tax ID Validation									
P0013	Billing Provider Number/ Rendering Provider Number Combo Validation	P0013	Billing Provider Number/Rendering Provider Number Combo Validation	P0013 Billing Provider Number _____ Rendering Provider Number _____ on service line _____ is NOT valid. Please correct and resubmit.	A3	122	A3	153	Billing Provider Number - 2010AA.REF02 when REF01 = 1A or 1B  Rendering Provider Number - 2310B.REF02 or 2420A.REF02 when REF01 = 1B	The rendering provider ID does not match the billing provider ID submitted on the claim. The provider must resubmit the claim using an individual provider number that matches the billing provider number.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
N/A	N/A	<b>P0014a</b>	Invalid Alpha Prefix	P0014a:EE00 The first 3 characters in the member ID number submitted were invalid. Please submit the ID number as it appears on the patient's identification card, without spaces, hyphens, dashes, or other special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The plan prefix submitted with the member ID was invalid. The provider should resubmit the claim with the appropriate member ID.
U1{DC}	Invalid USI number was submitted	<b>P0014b</b>	Universal Subscriber Identification Number Not Found	P0014b:EE01 The Universal identification number submitted was not valid. Please submit the full 13 character ID as it appears on the patient's card, without spaces, hyphens, dashes, or other special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014c	Invalid Contract for NAIC	P0014c:EE02 Based on the member ID number submitted, the patient does not subscribe to a product under the company you submitted the claim to. Please resubmit with a valid Member ID for the company specified.	E0	116	N/A	N/A	2010BA.NM109 or 2010CA.NM109 and 2010BB.NM109	<p>The member ID submitted on the claim was not valid based on the NAIC code submitted. Please resubmit the claim with the appropriate NAIC code based on the member's coverage.</p> <ul style="list-style-type: none"> <li>• 95056 – KEYSTONE</li> <li>• 54704 – PA PPO</li> </ul> <p>Note: If the provider/vendor is submitting the claims through Emdeon, the provider/vendor should use the Emdeon payer codes. Emdeon will convert the payer codes to our NAIC codes.</p>
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014d	Active Coverage Not Found for Date(s) of Service	P0014d:EE03 Based on the member ID number submitted, the patient does not have active coverage during the specified date(s) of service.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109 and 2400. DTP03 when DTP01 = 472	<p>The member ID submitted on the claim was not valid on the date of service submitted on the claim. The provider must resubmit the claim with a valid member ID.</p>
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014e	Member Not Found based on Member ID	P0014e:EE04 Based on the member ID submitted, the patient was not found. Please resubmit the full ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or any special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	<p>The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.</p>

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014f	Member Not Found based on Member ID and Date of Birth	P0014f:EE05 Based on the member ID and the patient Date of Birth submitted, the patient was not found. Please resubmit the full ID as it appears on the patient's ID card and the correct patient date of birth.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109 and 2010BA.DMG02 or 2010CA.DMG02	The member ID submitted on the claim was not valid based on the patient's date of birth. The provider must resubmit the claim with a valid member ID.
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014g	Member Not Found based on Member ID and Gender	P0014g:EE06 Based on the member ID and the patient Gender submitted, the patient was not found. Please resubmit the full ID as it appears on the patient's ID card and the correct patient gender.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109 and 2010BA.DMG03 or 2010CA.DMG03	The member ID submitted on the claim was not valid based on the gender of the patient. The provider must resubmit the claim with a valid member ID.
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014h	Invalid IBC/Keystone Patient ID Submitted	P0014h:EK00 The format of the patient's IBC/Keystone member ID is invalid. Please resubmit the full ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
U1{DC}	Invalid USI number was submitted	P0014i	Invalid IBC/Keystone Universal Patient Identification Number Format Submitted	P0014i:EK01 The Universal IBC/Keystone ID submitted was invalid. Please submit full 13 character ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID as it appears on the card.
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014j	Invalid IBC/Keystone Patient Identification Number Format Submitted	P0014j:EK02 The IBC/Keystone ID number submitted was not valid. Please submit the ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or any other special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	P0014k	Invalid IBC/Keystone Patient Identification Number Format Submitted	P0014k:EK03 The IBC/Keystone ID number submitted was not valid. Please submit the full ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or any other special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	<b>P0014l</b>	Invalid IBC/Keystone SSN Patient Identification Number Format Submitted	P0014l:EK04 The IBC/Keystone Patient SSN submitted was not valid. Please submit the full ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or any other special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member SSN submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID as it appears on the card.
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	<b>P0014m</b>	IBC/Keystone Patient Identification Number Submitted not an IBC/KHPE member	P0014m:EK06 The Patient identification number submitted is not on file at Independence Blue Cross. Please resubmit with a valid IBC/Keystone Member ID or contact your submitter or clearinghouse to correctly submit the claim.	E0	116			2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	<b>P0014u</b>	Invalid IBC/Keystone SSN Patient Identification Number Format Submitted	P0014u:EK05 The IBC/Keystone Member ID submitted was not valid. Please submit the full ID as it appears on the patient's card, including alpha and numeric characters, without spaces, hyphens, dashes, or any other special characters.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The member ID submitted on the claim was not valid. The provider must resubmit the claim with a valid member ID.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
4R{DC}	No record of eligibility based on submitted member ID and/or patient's date of birth.	<b>P0014ac</b>	Based on the Member ID, the claim should be submitted to Highmark	P0014ac: EE07 Based on the submitted Member ID, the claim should be processed at Highmark. Please resubmit the claim to Highmark for processing.	R1	21	XO	97	2010BA.NM109 or 2010CA.NM109	The submitted member ID suggests that the claim should be processed at Highmark. Please resubmit the claim to Highmark.
3102	Missing/Invalid NAIC (2010, NM109)	<b>P0015</b>	Payer NAIC Code Validation	P0015 The payer code ___ you submitted is missing or invalid. Please correct and resubmit.	A3	122	A3	153	2010BC.NM109	The NAIC code submitted on the claim is not valid for IBC. The provider must resubmit the claim with the appropriate NAIC code that is applicable to the LOB submitted on the claim.  • 95056 – KEYSTONE • 54704 – PA PPO  Note: If the provider/vendor is submitting the claims through Emdeon, the provider/vendor should use the Emdeon payer codes. Emdeon will convert the payer codes to our NAIC codes.
3114	Missing Adjustment Data (2300, NTE01)	<b>P0016b</b>	Missing Adjustment Note Description	P0016b When CLM05-3 is populated with 6, 7 or 8 indicating an adjustment request, the claim note segment is required. Please correct and resubmit.	A3	122	N/A	N/A	2300.NTE	The claim note is required when CLM05-3 equals 6, 7, or 8 because this indicates an adjustment request. The provider must resubmit the claim with the claim note. NTE01 must equal ADD and NTE01 must provide details explaining why the claim must be adjusted.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3219	Missing/Invalid Claim Filing Indicator	P0017	Claim Filing Indicator Validation	P0017 Claim Filing Indicator ___ is invalid. Valid claim filing indicators are BL and CI. Please correct and resubmit.	A3	122	N/A	N/A	2000B.SBR09	The claim filing indicator on the claim is not valid when submitting an IBC claim. The provider must submit the appropriate indicator.  The appropriate indicator is BL for IBC or Keystone claims.
3007	Missing/Invalid Place of Service	P0018	Place of Service Code Validation	P0018 The place of service ___ on service line ___ is missing or invalid. Please correct and resubmit the claim.	A3	122	A3	249	2400.SV105	The place of service code on the claim is invalid. The provider must resubmit the claim with a valid place of service code.
3007	Missing/Invalid Place of Service	P0019	Facility Type Code Validation	P0019 The facility type code ___ is missing or invalid. Please correct and resubmit.	A3	122	A3	249	2300.CLM05-1	The facility type code on the claim is invalid. The provider must resubmit the claim with a valid place of service code. The facility type code is the same as the place of service code.
3006	Missing/Invalid Claim Frequency Type Code	P0020	Claim Frequency Code Validation	P0020 The claim frequency type code ___ is missing or invalid. Please correct and resubmit.	A3	122	A3	535	2300.CLM05-3	The claim frequency type code on the claim is invalid. The provider must resubmit the claim with a valid claim frequency type code.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3242	Unit count required	P0021	Unit Field Validation	P0021 Unit field is null or zero ___ for service line ___. Please correct and resubmit.	A3	122	A3	476	2400.SV104	The unit(s) submitted on the service line is invalid; zero is not an allowable value. The provider must resubmit the claim with a valid unit count.
U5{DC}	Multiple units not appropriate with modifier 50	P0022	Procedure Code Modifier units validation	P0022 Multiple units ___ not allowed with this modifier ___. Please correct and resubmit.	A3	122	A3	476	2400.SV101-3, SV101-4, SV101-5 or SV101-6 equal "50" and 2400.SV104 is greater than "1"	The provider submitted an invalid unit count with the submission of modifier "50." The only allowable unit count is "1." Provider must resubmit the claim with the appropriate values.
C3{DC}	Data is required in Box 32 to process the claim	P0023a	Global Radiology and Laboratory Service Facility - Missing Facility Information	P0023a The service facility name, address and provider ID is required to process the claim. Please correct and resubmit.	A3	122	A3	153	2310D	The provider did not submit the service facility name, address, or provider ID. The provider must resubmit the claim with the appropriate information.
G1{DC}	Submitted number in Box 32 is not 10-digit Corporate ID	P0023b	Global Radiology and Laboratory Service Facility - Invalid Facility Number	P0023b The service facility provider ID ___ you submitted is not 10 digit number. Please correct and resubmit with your 10 digit service facility provider ID.	A3	122	A3	153	2310D.REF02	The service facility provider ID submitted on the claim was not equal to 10 digits. The provider must resubmit the claim with a valid 10-digit corporate ID number.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
G3{DC}	Submitted facility number in Box 32 is not valid	P0023c	Global Radiology and Laboratory Service Facility - Invalid Facility Number	P0023c The service facility provider ID ___ is invalid. Please correct and resubmit.	A3	122	A3	153	2310D.REF02	The service facility provider ID submitted on the claim was invalid. The provider must resubmit the claim with the appropriate service facility provider ID.
G2{DC}	Submitted number in Box 32 is not valid provider number for reported services	P0023e	Global Radiology and Laboratory Service Facility - Facility invalid for reported services	P0023e The service facility provider ID ___ is not valid for reported services. Please correct and resubmit.	A3	122	A3	153	2310D.REF02	The service facility provider ID submitted on the claim was invalid for services submitted. The provider must resubmit the claim with the appropriate service facility provider ID.
C3{DC}	Submitted facility number in Box 32 is not valid	P0024a	RAP Service Facility & Unidentified Provider - Missing Facility information	P0024a The service facility name, address and provider ID is required to process the claim. Please correct and resubmit.	A3	122	A3	153	2310D/REF02	The provider did not submit the service facility name, address, or provider ID. The provider must resubmit the claim with the appropriate information.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
C3{DC}	Data is required in Box 32 to process the claim	P0024b	RAP Service Facility & Unidentified Provider - Invalid Facility Number	P0024b The service facility provider ID ___ is invalid. Please correct and resubmit.	A3	122	A3	153	2310D	The service facility provider ID submitted on the claim was invalid. The provider must resubmit the claim with the appropriate service facility provider ID.
3235	Missing/Invalid Billing Provider Secondary Reference Number (2010AA, REF segment)	P0025	Missing Billing Provider Secondary Identification Number	P0025 The billing provider secondary reference number is missing. Please correct and resubmit.	A3	122	A3	153	2010.REF	The provider did not submit the billing provider secondary reference segment. The billing provider secondary reference segment should contain the provider's IBC billing provider number. The provider must resubmit the claim with the appropriate information.
N/A	Missing/Invalid Billing Provider Secondary Reference Qualifier (2010AA, REF01)	P0026a	Invalid Billing Provider Number Qualifier	P0026a Billing Provider Tax ID _____ is required and was not received. Please correct and resubmit.	A3	122	A3	128	2010AA.REF01 does not equal EI or SY	The provider submitted a qualifier that is not recognized by IBC as being a billing provider Tax ID number. The provider must resubmit the claim with the appropriate qualifier.  EI - Employer's Identification Number SY - Social Security Number

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3236	Missing/Invalid Billing Provider Secondary Reference Qualifier (2010AA, REF01)	P0026b	Invalid Billing Provider Number Qualifier	P0026b The Billing Provider secondary reference qualifier is invalid. Please correct and resubmit.	A3	122	A3	153	2010AA.REF01 does not equal 1A or 1B	The provider submitted a qualifier that is not recognized by IBC. The provider must resubmit the claim with the appropriate qualifier.  1A = IBC/Keystone 1B = IBC/Keystone
SD{DC}	Diagnosis code not to the highest specificity level	P0027	Diagnosis code not billed at highest level of specificity	P0027a The diagnosis code ___ not billed at highest level of specificity. Please correct and resubmit.	A3	122	A3	255	2300. HI01-2 when HI01-1 = BK and 2300. HI02-2 – HI08-2 when HI02-1 – HI08-1 = BF	The diagnosis code submitted on the claim was not at the highest level of specificity. There is a diagnosis code that is more specific. The provider must resubmit the claim with a valid diagnosis code.
3243	Claim sent to IBC in error, Please submit claim to Keystone Mercy Health Plan	P0029	Submit claim to Keystone Mercy Health Plan	P0029 Claim sent to IBC in error, please submit claim directly to Keystone Mercy.	A3	28	N/A	N/A	2010BA.NM109 or 2010CA.NM109 and AMT when AMT01 = F5	The Keystone Mercy Health Plan OOA claims must be submitted to IBC as secondary, and prior payments from the prior carrier must exist on the claim.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
NC{DC}	Not eligible for processing. Resubmit to Local Plan.	P0030	Non-Contiguous Ancillary Edit	P0030 Claim is not eligible for processing. Please resubmit to local plan via the BlueCard program.	A3	122	A3	153	2010AA.REF02 when REF01 = 1A or 1B	The billing provider number submitted on the claim is a member of another Blue Cross plan. The provider must resubmit the claim to their local Blue Cross plan via the BlueCard claim process.
NC{DC}	Not eligible for processing. Resubmit to Local Plan	P0031	Non-Contiguous Professional Claim Edit	P0031 Claim is not eligible for processing. Please resubmit to local plan via the BlueCard program.	A3	122	A3	153	2010AA.REF02 when REF01 = 1A or 1B	The billing provider number submitted on the claim is a member of another Blue Cross plan. The provider must resubmit the claim to their local Blue Cross plan via the BlueCard claim process.
3241	Invalid Date	P0032a	Invalid Subscriber Date of Birth	P0032a The subscriber date of birth ____ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2010BA.DMG02	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
3241	Invalid Date	P0032b	Invalid Patient Date of Birth	P0032b The patient date of birth ____ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2010CA.DMG02	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.

# Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3241	Invalid Date	P0032c	Invalid Onset of Current Illness Date	P0032c The initial onset of current illness/symptom date___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2300.DTP03 when DTP01 = 431	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
3241	Invalid Date	P0032d	Invalid Similar Illness Date	P0032d The similar illness/ symptom onset date___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2300.DTP03 when DTP01 = 438 (repeats 10 times)	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
3241	Invalid Date	P0032e	Invalid Disability Begin Date	P0032e The disability begin date___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2300.DTP03 when DTP01 = 360 (repeats 5 times)	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
3241	Invalid Date	P0032f	Invalid Admission Date	P0032f The admission date___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2300.DTP03 when DTP01 = 435	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3241	Invalid Date	P0032g	Invalid Discharge Date	P0032g The discharge date___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2300.DTP03 when DTP01 = 096	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
3241	Invalid Date	P0032h	Invalid Other Insured Date of Birth	P0032h The other insured date of birth___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2320.DMG02 (repeats up to 10 times)	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
3241	Invalid Date	P0032i	Invalid Service Line Date	P0032i The date of service___ on service line ___ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2400.DTP03 when DTP01 = 472	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3241	Invalid Date	P0032j	Invalid Disability End Date	P0032j The disability end date ____ is either after the file creation date or prior to 1900. Please correct and resubmit.	A3	122	A3	510	2300.DTP03 when DTP01 = 361 (repeats 5 times)	The provider submitted an invalid date. The date is either after the GS04 (file creation date) or the year was on or before 1900. The provider must resubmit the claim using the appropriate date.
P11{DC}	Rendering and Billing Prov #'s must be the same	P0033a	Billing and Individual provider ID must be the same on Ancillary claims	P0033a Billing and individual provider IDs must be the same on ancillary claims. Please correct and resubmit.	A3	122	A3	153	2010AA.REF or 2420A.REF when REF01 = 1A or 1B	The individual provider number on the claim is not the same as the billing provider number. The provider must resubmit the claim with the appropriate individual provider number.
P10{DC}	Place of Service not valid for Billing Provider	P0033b	Invalid Place of Service for Ancillary claim	P0033b The place of service ____ you submitted is invalid for an ancillary claim. Please correct and resubmit.	A3	122	A3	249	2400.SV105 or 2300.CLM05-1 and 2010AA.REF or 2420A.REF when REF01 = 1A or 1B	<p>The place of service on the claim is not valid for the ancillary provider type submitted on the claim. The provider must submit a valid place of service that is applicable for the ancillary provider.</p> <p><u>Place of Service - Ancillary Provider Type</u></p> <p>12 - HI (Home Infusion) 12 - DM (Durable Medical Equip) 12 - NU (Private Duty Nursing) 41 - AU (Ambulance) 42 - AU (Ambulance)</p>

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
P14{DC}	Procedure not valid for Billing Provider	P0033c	Procedure code not valid for Billing Provider on Ancillary claim	P0033c The procedure code ____ on service line ____ is not valid for billing provider. Please correct and resubmit.	A3	122	A3	507	2400.SV101-2 and 2010AA.REF or 2420A.REF when REF01 = 1A or 1B	The procedure code on the claim is not valid for the billing provider type submitted on the claim. The provider must submit a valid procedure code that is applicable for the ancillary provider.
P13{DC}	NDC code not present	P0033d	NDC code required for Ancillary claim	P0033d The NDC code is required for Home Infusion claim. Please correct and resubmit.	A3	122	A3	218	2410.LIN03	The claim was submitted without the NDC code for a home infusion provider. If the procedure code begins with a "B" and if procedure codes J7190 - J7195 or J7198 - J7199 are submitted on the claim, the NDC code is required.
3103 3104 3105	_Missing Other Payers Liability Data (2320 or 2430 CAS01), _Missing Other Payers Liability Data (2320 or 2430 CAS02) _Missing Other Payers Liability Data (2320 or 2430 CAS03)	P0034a	Missing OPL adjustment information	P0034a When SBR09 is "S" (Secondary) or "T" (Tertiary), the other payer liability adjustment information is required. Please correct and resubmit.	A3	122	A3	171	2320.CAS or 2430.CAS	The claim was submitted without the required data elements that are needed to adjudicate an Other Party Liability (OPL) claim. The provider must resubmit the claim with the appropriate data.
3106	Missing Other Payers Liability Data (2320, AMT02 Payer Amount Paid)	P0034b	Missing OPL paid amount	P0034b When SBR09 is "S" (Secondary) or "T" (Tertiary), the other payer liability amount is required. Please correct and resubmit.	A3	122	A3	171	2320.AMT02 when AMT01 = D	The "Payer Amount Paid" information is required when SBR01 is "S" (Secondary) or "T" (Tertiary). These indicators denote that another payer paid the claim. The provider must resubmit the claim with the appropriate data.

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
3117	Missing Other Payers Liability Data (2320, AMT02 Patient Responsibility Amount)	P0034c	Missing OPL patient responsibility amount	P0034c When SBR09 is "S" (Secondary) or "T" (Tertiary), the other payer liability patient responsibility amount is required. Please correct and resubmit.	A3	122	A3	171	2320.AMT02 when AMT01 = F2	The "Patient Responsibility Amount" is required when SBR01 is "S" (Secondary) or "T" (Tertiary). These indicators denote that another payer paid the claim. The provider must resubmit the claim with the appropriate data.
3107	_Missing Other Payers Liability Data (2320A, NM101)	P0034d	Missing OPL entity name or organization information	P0034d When SBR09 is "S" (Secondary) or "T" (Tertiary), the other payer name is required. Please correct and resubmit.	A3	122	A3	171	2320.NM1	The "Other Payers Information" is required when SBR01 is "S" (Secondary) or "T" (Tertiary). These indicators denote that another payer paid the claim. The provider must resubmit the claim with the appropriate data.
3108	_Missing Other Payers Liability Data (2320A, NM102)									
3109	_Missing Other Payers Liability Data (2320A, NM103)									
3110	_Missing Other Payers Liability Data (2320A, NM104)									
3111	_Missing Other Payers Liability Data (2320A, NM108)									
3112	_Missing Other Payers Liability Data (2320A, NM109)									

## Claims Preprocessing Edits Claims Resolution Document

Current Error Rejections		New Pre-processor Rejections		New Error Descriptions	U277 Details				Claim Resolution Instructions	
A		B		C	D				E	F
Error Code	Description	CPPS Error Code	General Description	Description Reported on the • U277 - STC12 • Rejected Claim Report	Primary Status U277 Elements		Secondary Status U277 Elements		837P Loop/Data Element	Error Resolutions
					STC01-1	STC01-2	STC10-1	STC10-2		
N/A	N/A	P0035a	Invalid NPI Check Digit Validation	P00035a The Billing Provider NPI _____ you submitted failed check digit validation. Please correct and resubmit.	A3	122	A3	562	2010AA.NM109 when 2010AA.NM108 equal XX	The billing provider NPI submitted on the claim is invalid. The provider must resubmit the claim using a valid billing provider NPI.
N/A	N/A	P0035b	Invalid NPI Check Digit Validation	P00035b The Rendering Provider NPI _____ you submitted failed check digit validation. Please correct and resubmit.	A3	122	A3	562	2010AA.NM109 when 2010AA.NM108 equal XX	The rendering provider NPI submitted on the claim is invalid. The provider must resubmit the claim using a valid rendering provider NPI.
N/A	N/A	P0035c	Invalid NPI Check Digit Validation	P00035c The Service Facility NPI _____ you submitted failed check digit validation. Please correct and resubmit.	A3	122	A3	562	2010AA.NM109 when 2010AA.NM108 equal XX	The service facility NPI submitted on the claim is invalid. The provider must resubmit the claim using a valid service facility NPI.