



Independence
Blue Cross

www.ibx.com

October 2007

Feedback on *Partners in Health Update*

We have been publishing *Partners in Health Update* electronically for six months — and we welcome your feedback.

If you would like to share your comments or suggestions regarding the new electronic process, please email us at provider_communications@ibx.com.

Your viewpoint will help us improve the way we work and communicate with you. Thank you for your participation in our network and for your commitment to the delivery of high-quality health care to our members, your patients.

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

-  Professional
-  Facility
-  Ancillary

PARTNERS IN HEALTH UPDATE








Working Together For Quality Health Care

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Additional copies of *Partners In Health Update* can be printed by going to our website www.ibx.com/providers/communications.

NPIs must be registered with IBC



NPI-only claims will reject if NPI is not registered with IBC

As previously stated in our NPI Contingency Plan, NPI-only claims will reject if providers have not registered their NPIs with us. IBC has the ability to accept claims with an NPI as the primary identifier if providers have registered their NPI with us.

Providers must register their NPI with IBC prior to submitting NPI-only claims.*

Registering your NPI(s) with IBC

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.

Registering your NPI with IBC is easy. Once you have obtained your NPIs, please submit them to us by completing and returning your custom IBC NPI Submission Form (included in our mailings to participating provider offices). Please contact your Network Coordinator with questions regarding your custom IBC NPI Submission Form.

NPIs will be required for new practitioners who request participation with IBC. The NPI, if not already registered, will also be requested as part of the recredentialing process.

IBC’s contingency plan: Dual use

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 Centers for Medicare & Medicaid Services (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 periodically assess provider readiness and the continued necessity of its dual use strategy. Once IBC determines that a sufficient percentage of providers have registered their NPIs with us and

How to obtain an NPI

National Plan and Provider Enumeration System (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
- ▶ **Mail:**
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

NATIONAL PROVIDER IDENTIFIER (NPI)

NPIs must be registered with IBC (*continued*)

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' notice to providers, their clearinghouses, and vendors before implementing this change. However, after May 23, 2008, the NPI must be present on inbound and outbound transactions.

More information about IBC's NPI Dual Use Claims Submission, including the entire IBC NPI Contingency Plan, electronic and paper claim submission instructions, and relevant FAQs, is available at www.ibx.com/providers/npi.

**IBC will receive contracted Behavioral Health Providers' NPI information directly from Magellan Behavioral Health, Inc. For further information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit them at www.MagellanHealth.com.*

NPI Web Resources

IBC provider NPI website

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/

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

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

BILLING

IBC will soon reject paper claims submitted on forms CMS-1500 (12/90) and UB-92



Effective December 17, 2007, IBC will no longer accept paper claims submitted on forms CMS-1500 (12-90) and UB-92. All paper claims received on or after December 17, 2007, must be submitted on

revised forms CMS-1500 (08-05) and UB-04. Paper claims submitted on forms CMS-1500 (12-90) and UB-92 will reject as of December 17, 2007.

Statement of remittance (SOR) enhancement



We are excited to announce that effective October 2007, the state of remittance (SOR) will use a new format to report claim payments. We listened to your feedback and worked collaboratively with a group of facility and professional providers to develop a new, streamlined SOR.

Highlights of the new format include:

- an easy-to-read landscape layout;
- remark codes with definitions after each claim to make posting easier for billing offices;
- the inclusion of contact phone numbers on the summary page;
- summaries of inpatient facility claims for ease of posting (when there is only one payment reimbursement);

- suppressed lines on adjustments when changes do not affect the payment;
- simplified sorting and subtotaling;
- a redefinition of the *Allowed Amount* column to contain the *Contract Amount*;
- interest amount (if applicable) included with each claim;
- subtotals (by product) on the back of the SOR.

Included with this edition of *Partners in Health Update* is a detailed four-page overview of the new SOR, which provides concise definitions of the headers, numbers, and remarks, that you need to understand in order to interpret your SOR.

Please contact your Network Coordinator if you have questions regarding the new enhancements.

Anesthesia billing requirements



IBC plans to implement claim system enhancements beginning November 9, 2007, which will improve accuracy and efficiency of anesthesia claims processing. Adhering to the following anesthesia billing requirements is necessary to facilitate correct billing and minimize the need for claim adjustments and resubmissions.

- Providers should not bill expected units. Actual anesthesia time should always be reported in minutes, except when reporting services that are reimbursed at a “flat rate.” Time in “total minutes” should be reported in block 24G of the CMS-1500 claim form.

- Providers billing for general anesthesia services must use a valid anesthesia CPT®* code. Do not bill using surgical CPT codes.

* 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 AMA.

More news about Medicare Private Fee-for-Service



As announced in previous editions of *Partners in Health Update*, our new Medicare Advantage Private Fee-for-Service (PFFS) product called Select Advantage will be **effective January 1, 2008**.

Early this month, you will receive a letter detailing this new product. The letter will also provide you

with information on where to access necessary forms and documents related to this new product.

Be sure to continue checking this section in future editions of *Partners in Health Update* for additional information on our new PFFS plan.

NAVINET®

Drug preauthorization on NaviNet®



Last month, all drug preauthorization forms were made available through NaviNet. This latest portal enhancement includes additions to the preauthorization forms as well as improved criteria questions written to assist you in the submission process.

The preauthorization forms for those oral and injectable drugs that can be administered by the member or family are accessible from the *Plan Transaction* menu under *Drug Preauthorization and Formulary*.

Preauthorization requests for injectable drugs that are administered as an infusion (either in a physician's office or as an outpatient) can be made by navigating to the *Chemotherapy/Infusion transaction* under *Authorizations* on Plan Central.

For assistance with these or any other transactions offered through NaviNet, providers should consult the User Guides under *Customer Service* or contact NaviNet Customer Care at 1-888-482-8057.

Medicare Part D vaccines ordering instructions



As you may be aware with the implementation of Medicare Part D, there are three vaccines that are covered through the Part B benefit — hepatitis B (for intermediate and high risk individuals), influenza, and pneumococcal vaccines. These vaccines can continue to be administered and billed as usual. **All** other vaccines, including childhood vaccines, are covered under Part D through the member's pharmacy benefit.

As a reminder, all Part D vaccines will not be paid through the member's medical benefit. They must be billed through the member's Part D/pharmacy benefit.

If a Part D vaccine is needed, there are two options available:

- **Write a prescription** — Fill out a prior authorization form and write a prescription for the Part D vaccine that a member could take to a retail pharmacy. The member will be charged their appropriate Part D copay/coinsurance and the vaccine will count against their true out-of-pocket (TrOOP) expense. The member would bring the vaccine back to the office for administration.
- **Use the Direct Ship Injectable process** — The vaccine can be shipped to your office for administration. Please refer to the process in the sidebar. (*Excludes Keystone 65 Complete Members.*)

Please refer to the following information when participating in the FutureScripts® Secure Direct Ship Injectables Program:

- Complete and fax the Direct Ship Injectables Request Form to 215-761-9165. Download the Direct Ship Injectables Request Form at www.site65.com/pdfs/plan_finder/drug_formulary/libc_direct_ship_injectable_request.pdf.
- The medication will then be shipped to the specified address, five to seven business days after FutureScripts Secure receives the completed form.
- The injectable distributor will bill us directly, eliminating the need for you to bill for reimbursement of the drug.
- Any ordered refills will not require a new form. If you require a request form, call FutureScripts Secure at 1-888-678-7015 (option #3), and the form will be promptly faxed to you. You may download the request form directly from our website. Refills will be coordinated by our injectable distributor without additional paperwork.
- Quantities for vaccines will be evaluated to promote appropriate prescribing.
- Medications obtained through the program may be subject to the member's contract exclusions and medical necessity review. For Keystone 65 complete Members, please contact 1-800-684-5501, or complete and fax the Injectables Request Form to 1-866-533-5498 (for non-urgent requests) or 1-866-546-7972 (for urgent requests).

For more information, please contact Provider Services.

Medicare Part D fraud, waste, and abuse



The Medicare Part D drug benefit has been called one of the most sweeping initiatives taken on since the advent of the Medicare program. Because of its complexity, the Part D benefit also provides opportunities for fraud, waste, and abuse. As a Plan Sponsor of the Part D benefit, IBC is required to establish a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse within the Part D benefit program.

As a valued provider, you can assist IBC in identifying the unscrupulous individuals who exploit the Part D benefit. Examples of fraud, waste, and abuse include, but are not limited to, the following:

- Plan Sponsors, brokers, or agents who violate the Medicare marketing guidelines by offering beneficiaries inducements to enroll;
- sponsors or pharmacy benefits managers who make inappropriate formulary decisions;
- pharmaceutical companies offering kickbacks or other inappropriate incentives to providers who prescribe their drugs;

- providers who write prescriptions for drugs that are not medically necessary;
- pharmacists who provide less than the prescribed quantity;
- manipulation of a beneficiaries TrOOP (true out-of-pocket) expense;
- beneficiaries who forge or alter a prescription;
- beneficiaries who consult a number of doctors so they can obtain multiple prescriptions for narcotic pain killers or other drugs (a practice often known as doctor-shopping).

You play an important role in helping us control the costs of the Part D benefit. If you know or suspect fraud, waste, or abuse, or if you have a compliance issue, please call our toll-free hotline at 1-866-282-2707. You can also submit an electronic report at www.ibx.com/anti-fraud.

POLICY

Decongestive lymphedema therapy Policy # 07.06.01a



IBC has revised its medical policy addressing Decongestive Lymphedema Therapy (DLT). Providers should report DLT services with the global HCPCS code S8950 (complex lymphedema therapy, each 15 minutes.)

In geographic areas with capitated physical therapy programs, DLT is excluded from physical therapy capitation when reported with HCPCS code S8950.

For more information, please contact your Network Coordinator, or visit www.ibx.com/medpolicy to view the medical policy in its entirety.

Heart failure video program promotes self-care



Heart failure patients can have a tremendous impact on their functional and symptomatic status and on their overall well-being if they know how to properly manage their condition. Many patients, for example, could avoid the need for emergency services to treat pulmonary edema if they knew how to detect the signs of imminent decompensation and they practiced appropriate self-care. Indeed, worsening heart failure symptoms are often linked to diuretic nonadherence and/or excessive sodium consumption. Additionally, patients often overlook clues, such as sudden weight gain or peripheral edema, that could help them preempt medical emergencies.

Unfortunately, most patients do not fully grasp the potential impact of missing a diuretic, overindulging in salt, or of gaining a few pounds of fluid weight. That is why we now offer members the Shared Decision-Making® video and booklet program “Living with Heart Failure: Helping Your Heart Day-to-Day.”

The program uses lay language and interviews with real heart failure patients to teach patients the most important steps they can take to preserve their health. In particular, the program underscores the importance of uninterrupted diuretic use, consistent sodium restriction, and daily weighing.

Using animation and other visuals, the program explains the relationship between heart failure symptoms, kidney function, and fluid retention. As a result, viewers learn to make the connection between breathlessness and salty indiscretions — a connection that is conceptually difficult for many to make.

Sodium restriction

Because people are often under the mistaken impression that sodium restriction means merely avoiding the saltshaker, the program lists the specific steps involved in following a sodium-restricted diet. Viewers learn, for example:

- the sodium people consume comes mostly from processed and prepackaged foods rather than from salt added in food preparation.

- which foods to avoid and which foods make good choices.
- sodium lurks in unexpected places, such as antacids, laxatives, and sleep-aids.

Daily weighing

Like the section on sodium, the program's section on daily weighing provides detailed practical information. It teaches viewers they must weigh themselves at the same time each day, in the same state of dress, and they must keep a record of each weight. The program teaches people that weight monitoring has nothing to do with “fat” weight. In fact, viewers learn that significant weight changes, like symptomatic changes, should prompt a call to their doctor or the use of an action or symptom-response plan.

Action or symptom — response plan

Since many people with heart failure do not have an action or symptom-response plan, the program encourages viewers to develop one with their doctors. These plans, which can be tailored to each patient's individual needs, can help patients determine when they need to call their provider and when some other action is appropriate.

Member resources

The video and booklet provide patients with comprehensive, evidence-based, unbiased information vetted by the Foundation for Informed Medical Decision Making, a nonprofit organization dedicated to improving the quality of medical decisions. Most importantly, it encourages patients to work with their doctors to find the best way to cope with their limitations and improve their health.

To find out more about the “Living with Heart Failure: Helping Your Heart Day-to-Day” video and other Shared Decision-Making® services, contact the ConnectionsSM Health Management Program Provider Support Line at 1-866-866-4694. A Connections Provider Service Specialist will return your call within two business days. As always, a member can speak with a Connections Health Coach about heart failure or can request the video by calling 1-800-ASK-BLUE, prompt 2.



National breast cancer awareness month

The Centers for Disease Control and Prevention (CDC) recommends mammography screening as the best available method to detect breast cancer in its earliest, most treatable stage. However, according to a study published in the June 15 issue of *Cancer*, the proportion of U.S. women 40 and older who report having a mammogram in the previous two years declined from 70 percent to 66 percent from 2000 to 2005.

Although the number of breast cancer cases has dropped in the past few years, this decline in mammography adherence may mean that some women with early-stage disease will not be diagnosed until later.

Because we recognize the importance of this screening, we want to remind you how we have made mammograms more accessible to our members:

- Copayments, deductibles, and coinsurance are not applied to mammograms performed in-network.
- Members may go anywhere in the radiology network for screening and diagnostic mammograms.

IBC makes access to these tools easy

Breast cancer risk assessment tool

Based on the Gail model, this computer program developed by the National Cancer Institute estimates a woman's five-year and lifetime risk of developing breast cancer. Women identified as high-risk may be offered chemoprophylaxis against breast cancer.

Find the tool on www.ibx.com/providers by selecting *Resources for Your Patients*, then clicking on the *Internet Resources & Bulletins* link.

Mammography screening reminder program

IBC mails mammography screening reminders annually to all female members 40 and older.

IBC's member portal website, www.ibxpress.com, includes:

- breast cancer information
- email reminders to schedule a mammogram. (Members may register for a reminder from the American Cancer Society's "Once Is Not Enough" email program.)

Decision Support videos

Five breast cancer videos are available on topics ranging from early-stage breast cancer to breast reconstruction. A complete listing of Decision Support videos and other ConnectionsSM Health Management Program information and tools can be found at www.ibx.com/providers. Providers can call the Connections Program Provider Support Line at 1-866-866-4694 for information about the Connections Program, to make referrals to the program and for support regarding Connections.*

The following American Cancer Society programs are available on www.cancer.org or by calling 1-800-ACS-2345:

- **"Reach to Recovery."** "Reach to Recovery" has been helping breast cancer patients cope with breast cancer for more than 30 years. This program matches a trained volunteer breast cancer survivor with a newly diagnosed person to offer support and hope.
- **"Look Good...Feel Better."** "Look Good...Feel Better" is a free, community-based program that teaches female cancer patients beauty techniques to help restore their appearance and self-image while they undergo radiation and chemotherapy treatments.

*The Decision Support videos are available for members eligible for the Connections Health Management Program.

REMINDER

Laboratory services reminder



We encourage providers to set up accounts with designated laboratory sites to accommodate testing needs, improve record keeping, promote communication between the laboratory and the physician, and facilitate timely receipt of laboratory supplies. Keep in mind that any referral to a nonparticipating laboratory or nonparticipating provider requires prior authorization from IBC.

For more information, please look in the *Provider Manual* under Laboratory Services in the Specialty Programs and Laboratory Services section. You can find laboratory indicators on the member identification card next to the ID number, via NaviNet®, and/or the IVR. Please refer to the following list of participating contracted laboratories for outpatient services:

Laboratory name	Laboratory indicator	Phone number
Abington Memorial Hospital Laboratory	A	215-481-2331
Health Network Laboratories	N	1-877-402-4221
Hospital of the University of Pennsylvania Laboratory*	H	1-800-789-7366
Laboratory Corporation of America	L	1-866-297-3210
Mercy Health Laboratory	M	610-237-4175
Quest Diagnostics, Inc.	Q	1-800-825-7320
Seneca Medical Lab, Inc.	Z	1-877-373-6322
SMA Medical Laboratories	F	215-322-6590
Thomas Jefferson University Laboratory*	T	215-955-6545

* Available to specific practices only.

Laboratory services reminder (*continued*)

Specialized pathology testing is offered by the designated laboratories as well as by the following specialized *participating* laboratory providers:

Laboratory name	Specialty	Phone number
Ameripath New York, Inc.	Dermatopathology only	1-800-553-6621
Dianon	Dermatopathology/pathology	1-800-328-2666
Genzyme Genetics	Reproductive/Genetic/Oncology testing only	1-800-848-4436 (Reproductive and Genetic Testing) 1-800-447-5816 (Oncology Testing)
Institute for Dermatopathology	Dermatopathology only	610-260-0555
Litholink	Kidney Stone Prevention	1-800-338-4333
Penn Cutaneous Pathology	Dermatopathology only	1-866-337-6522

Home phlebotomy may be available when members are homebound. Services may be arranged by contacting a contracted home phlebotomy provider. Some designated labs also offer home phlebotomy for patients living in assisted-living or non-skilled nursing homes. This service is covered only as defined by Medicare Guidelines. Medicare Guidelines are used for all members regardless of coverage.

Our contracted home phlebotomy provider is Professional Technicians. Professional Technicians will perform the home draw only and deliver the sample to a participating designated laboratory (HMO) or participating lab/hospital (PPO).

You may contact Professional Technicians at [215-364-4911](tel:215-364-4911). In addition, DeJohn Medical Lab is contracted as a home draw provider for Keystone 65 Complete members. DeJohn Medical Lab can be contacted at [610-626-2112](tel:610-626-2112).

HMO/POS: All routine laboratory services for HMO/POS members must be directed to and processed by the PCP's designated laboratory site. This is not a statement of benefits.

Benefits may vary based on state requirements, product line (HMO, PPO, etc.), contract, or employer group. Individual member coverage must be verified with IBC. Please contact Provider Services for more information on specific benefit coverage.



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.

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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.

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IMPORTANT RESOURCES

View our online provider directories at www.ibx.com

CARE MANAGEMENT AND COORDINATION 215-567-3570
Case Management 1-800-313-8628*

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

CONNECTIONSSM HEALTH MANAGEMENT PROGRAMS
ConnectionsSM Health Management Program Provider Support Line 1-866-866-4694

ConnectionsSM Kidney Program 1-866-303-4CKP (4257)

ConnectionsSM AccordantCareTM Program 1-866-398-8761

CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT 1-866-282-2707
Anti-Fraud and Corporate Compliance Hotline www.ibx.com/anti-fraud

CREDENTIALING VIOLATION HOTLINE 215-988-6534
www.ibx.com/credentials

eBUSINESS 215-241-2305
Help Desk

eBusiness Provider Hotline 215-640-7410

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

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

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

FutureScripts® Secure 1-888-678-7015
Medicare Part D

HEALTH RESOURCE CENTER 215-241-3367
Healthy LifestylesSM 1-800-275-2583*

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

PROVIDER ELECTRONIC DATA INTERCHANGE SERVICES WEB PAGE www.ibx.com/edi

PROVIDER INFORMATION and TOOLS WEB PAGE www.ibx.com/providers

PROVIDER MEDICAL POLICY WEB PAGE www.ibx.com/medpolicy

PROVIDER PHARMACY WEB PAGE www.ibx.com/provider_rx

PROVIDER SERVICES (Policies/Procedures/Claims) 215-567-3590
HMO 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**

*SOR: How to Read Your **Professional** Statement of Remittance* was published along with this edition of *Partners in Health Update*.

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

SOR

How to read your Professional Statement of Remittance

Ancillary Providers: Refer to this form only when working with Professional providers



INTRODUCTION

We are excited to announce that effective October 2007, the Statement of Remittance (SOR) will use a new format to report claim payments. We listened to your feedback and worked collaboratively with a group of facility and professional providers to develop a new streamlined SOR.

Highlights of this new SOR include:

- an easy-to-read landscape format;
- remark codes with definitions after each claim to make posting easier for billing offices;
- the inclusion of contact phone numbers on the summary page;
- summaries of inpatient facility claims for ease of posting (when there is only one payment reimbursement);

- suppressed line items on adjustment when changes do not affect payment;
- simplified sorting and subtotalling;
- a redefinition of the *Allowed Amount* column to contain the *Contract Amount*;
- interest amount (if applicable) included with each claim;
- subtotals (by product) on the back of the SOR.

This document provides a detailed overview of the SOR, with concise definitions of the headers, numbers, and remarks that you need to understand to interpret your SOR. Please use this document as a reference tool for your office.

Please contact your Network Coordinator if you have questions regarding these enhancements.

SOR SUMMARY PAGE

The image shows a sample SOR Summary Page and a check. The SOR Summary Page includes the Independence Blue Cross logo, address, and contact information. It features a table with the following data:

CHECK NBR	997777772	DATE	6/04/2007	AMOUNT	\$663.99
PAYMENT SUMMARY					
NET CLAIM AMOUNT:				\$1,183.73	
MONIES DUE AMOUNT TAKEN:				\$525.00	
LATE PAYMENT INTEREST PAID:				\$5.26	
TOTAL AMOUNT DISBURSED:				\$663.99	

Below the table is a smaller summary box with the same totals and the note: "THIS PAYMENT HAS BEEN MADE ELECTRONICALLY". The effective entry date is 6/06/2007. A barcode and NPI information are also present.

The check below is a "SAMPLE CHECK" for \$663.99, payable to WE CARE PHYSICIANS, dated 6/04/2007. It includes the Independence Blue Cross logo and the text "NON-NEGOTIABLE".

SOR SUMMARY DEFINITIONS

The first page of each SOR is a **Summary Page** that displays addresses, contact information, financial totals, and payment information; i.e., either a check or a summary of the Electronic Funds Transfer (EFT).

- 1 Phone Numbers** — Use the appropriate Provider Services hotline number for specific questions regarding how a claim was paid.
- 2 Net Claim Amount** — The net amount disbursed prior to application of offsets.
- 3 Monies Due Amount Taken** — The amount of offsets applied on the payment.
- 4 Late Payment Interest Paid** — The total of any interest paid for claims paid late.
- 5 Total Amount Disbursed** — The total amount paid.
- 6 Electronic Payment Summary** — If you receive an EFT payment, the summary displays the amount and the effective date.
- 7 Important Messages** — Look for important messages from IBC on the SOR Summary Page.
- 8 Check** — If a check has been issued, it will be attached to the bottom of the summary page.

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.

SOR DETAIL PAGES



Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and with Highmark Blue Shield. Independent Licensees of the Blue Cross and Blue Shield Association.

9 PAY TO: WE CARE PHYSICIANS
10 PAY TO ID: 9999999999 DOCUMENT ID: 0604UCDS02010000241
 NPI: 1212121212 DATE: 6/04/2007
 CHECK NUMBER: 9977777772 PAGE: X OF XX

11 BILLING PROVIDER ID: 5555555555 **15** BILLING PROVIDER NAME: THEODORE W. PHYSICIAN **17** **19** **20**

12 PPO PATIENT NAME: APPLE, MARY **16** PT ACCT: 5555555555 **21** INSURED NAME: APPLE ROGER **22** USI NBR: 8888888888 **23** SS/CLM NBR: MH/666666666694 **24** **25** **26**

DATES OF SERVICE	PROC/REV CODE	POS	TOT UNITS	AMOUNT BILLED	ALLOWED AMT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	REMARK CODE(S)	AMOUNT PAID
5/16/07	99397	11	1	\$150.00	\$119.07	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 R03	\$119.07
5/16/07	G0101	11	1	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 PBR	\$0.00
5/16/07	Q0091	11	1	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 P89, BD3	\$0.00
5/16/07	82270	11	1	\$30.00	\$5.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$5.00

13 **14** **18** **30** **31**

27 **28** **29** **32**

EXPLANATION OF REMARKS: (R03) INCIDENTAL PROCEDURES ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT. PROVIDER LIABILITY. (PBR) THE SERVICE IS CONSIDERED MUTUALLY EXCLUSIVE. REIMBURSEMENT IS INCLUDED IN PAYMENT FOR OTHER PROCEDURES. (P89) INCIDENTAL PROCEDURES ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT. PROVIDER LIABILITY. (BD3) THE PROVIDER OF THIS SERVICE(S) WAS NOT ELIGIBLE TO PERFORM THIS SERVICE PER THE PROVISION OF THE BENEFIT/PROVIDER CONTRACT.

TOTAL FOR THEODORE W. PHYSICIAN
 PROV NON-COV \$0.00 PENALTY \$0.00 AMOUNT BILLED \$280.00 ALLOWED AMT \$124.07 MEM NON-COV \$0.00 DEDUCTIBLE \$0.00 CO-PAYMENT \$0.00 COINSURANCE \$0.00 MEM RESP \$0.00 OTHER INS PAY \$0.00 AMOUNT PAID \$124.07

BILLING PROVIDER ID: 8888888888 BILLING PROVIDER NAME: KERRY A. GOODDOCTOR

PPO PATIENT NAME: GOODY, MARTHA T PT ACCT: 5555555555 INSURED NAME: GOODY ANDREW J. USI NBR: 5555555555 SS/CLM NBR: MH/777777777779, 777777777779

DATES OF SERVICE	PROC/REV CODE	POS	TOT UNITS	AMOUNT BILLED	ALLOWED AMT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	REMARK CODE(S)	AMOUNT PAID
5/17/07	99214	11	1	\$125.00	\$83.61	\$0.00	\$0.00	\$15.00	\$0.00	\$15.00	\$0.00 P89	\$88.61
5/17/07	94760	11	1	\$35.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5/17/07	94640	11	1	\$43.00	\$12.25	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$12.25
5/17/07	J7613	11	1	\$15.00	\$15.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 BD3	\$0.00

EXPLANATION OF REMARKS: (P89) INCIDENTAL PROCEDURES ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT. PROVIDER LIABILITY. (BD3) THE PROVIDER OF THIS SERVICE(S) WAS NOT



Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Ins. Co. and with Highmark Blue Shield. Independent Licensees of the Blue Cross and Blue Shield Association.

PAY TO: WE CARE PHYSICIANS
 PAY TO ID: 9999999999 DOCUMENT ID: 0604UCDS02010000244
 NPI: 1212121212 DATE: 6/04/2007
 CHECK NUMBER: 9977777772 PAGE: X OF XX

33

TOTAL FOR PPO	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID
	\$15.00	\$0.00	\$1,508.00	\$860.57	\$125.00	\$27.21	\$130.00	\$0.01	\$32.21	\$0.00	\$813.36

34

TOTAL FOR HMO	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID
	\$0.00	\$0.00	\$662.00	\$455.37	\$0.00	\$0.00	\$85.00	\$0.00	\$85.00	\$0.00	\$370.37

TOTAL PAYMENT	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID
	\$15.00	\$0.00	\$2,170.00	\$1,315.94	\$125.00	\$27.21	\$215.00	\$0.00	\$117.21	\$0.00	\$1,183.73

POS KEY:
 11 OFFICE VISIT

SOR SAMPLE ONLY

SOR DETAIL DEFINITIONS

Each SOR consists of an **SOR Detail** section (which can number several hundred pages) that displays concise information regarding your remittances. Totals are located on the final page of the section.

- 9 **Pay To Box (NPI)** — Identifies the NPI of the provider who will receive the payment
- 10 **Pay To Box (Check Number)** — Identifies the check number or document number of the payment.
- 11 **Billing Provider ID** — The servicing provider ID, or in some cases the billing provider ID.
- 12 **Product Identifier** — Indicates the product in which the member is enrolled (can include PPO, HMO, or Traditional).
- 13 **Dates of Service** — The date(s) that the member received health care services. The first date of service and the last date may be listed if a range is reported.
- 14 **Procedure/Revenue Code** — Describes the procedure or revenue code for each service.
- 15 **Place of Service (POS)** — Describes the location that the service was performed.
- 16 **Total Units** — The number of units for each service.
- 17 **Patient Account Number** — The number used by the provider to identify the member in the provider's system(s).
- 18 **Amount Billed** — The dollar amount charged by the provider for the services rendered.
- 19 **Allowed Amount** — The amount allowed (i.e., contract rate) for each covered service.
- 20 **Member Noncovered** — The dollar amount that is not covered by the member's benefits.
- 21 **Deductible** — The amount of covered expenses paid by the member before the insurance plan will assume any liability.
- 22 **Copayment** — A fixed or set amount that a member pays at the time a service is rendered.
- 23 **Coinsurance** — Percentage of the allowed amount that the member pays after the plan pays.
- 24 **Member Responsibility** — The amount owed by the member to the provider.
- 25 **Remark Codes** — Codes for payment explanations.
- 26 **Amount Paid** — The amount paid to the provider.
- 27 **Explanation of Remarks** — Provides the code and definitions of each payment explanation after each claim.
- 28 **Provider Noncovered** — The amount that is not covered according to the provider contract.
- 29 **Penalty** — Type of cost-sharing that insurance plans assess resulting in a reduction of payment.
- 30 **Other Insurance Payment** — The dollar amount paid by primary insurance coverage.
- 31 **Interest** — The interest amount (if due).
- 32 **Source System/Claim Number** — In cases where a claim is adjusted under a secondary claim number, both claim numbers will display separated by a comma.
- 33 **Product Totals** — The type of coverage the member has is listed and then totaled at the end of the SOR.
- 34 **POS Key** — Defines the Place of Service code (see definition #15).

NaviNet®: Get Your SOR Online

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ACCOUNTS RECEIVABLE (A/R) DETAIL PAGE

CHECK NO 297777772 DATE 6/04/2007 PAGE X OF XX
THIS IS NOT A BILL

RECIPIENT ID: 999999999 SUFFIX: BC00
NAME: ME CARE PHYSICIANS

STATEMENT: MONIES DUE OPEN ITEMS, BALANCES, TRANSACTIONS

41 MONEY DUE COMPANY STATUS: T - TO BE CLOSED

36	ENTERED	ACTIVATED	START AMOUNT	REMAINING BAL	LAST ACTIVE
	06/01/07	06/01/07	\$25.00	0.00	06/04/07

42 PROVIDER PATIENT ID: 444444444

43 DATE OF SERVICE: 8/04/2006

44 PATIENT NAME: A PATIENT

45 COMPANY PATIENT ID: 666666666

46 BENEFITS ARE NOT APPROVED. THE PATIENT HAS NOT ELIGIBLE FOR BENEFITS AT THE TIME THE SERVICE WAS PROVIDED.

ACTIVITY TO DATE:

46	DATE TAKEN	AMOUNT TAKEN	RUNNING BAL	PAYMENT NUMBER	BANK CODE
	06/04/07	393.48	171.52	997777772	BC
47	TOTAL	\$25.00	0.00		

STATEMENT OF MONIES

DATE TAKEN - DATE WHEN MONEY DUE WAS FROM A PAYMENT BEING MADE.
AMOUNT TAKEN - AMOUNT TAKEN, CANNOT EXCEED PAYMENT AMOUNT.
RUNNING BALANCE - AMOUNT STILL DUE AFTER TAKEN AMOUNT.
PAYMENT NUMBER - IDENTIFICATION OF PAYMENT, CHECK NUMBER OR ACH ID.
BANK CODE - THIS IS THE DOCUMENT AFFECTED BY THE ACTIVITY.

48 49 50 51

SOR SAMPLE ONLY

INTEREST STATEMENT PAGE

CHECK NO 297777772 DATE 6/04/2007 PAGE X OF XX
THIS IS NOT A BILL

RECIPIENT ID: 999999999 SUFFIX: BC00
NAME: ME CARE PHYSICIANS

LATE CLAIM PAYMENT INTEREST PAID

52	CLAIM PAID LATE	53	RECEIPT DATE	54	RESET DATE	55	I-RATE	56	PAY DATE	57	IN	58	LATE	59	CLAIM AMOUNT	60	INTEREST
	777777772		3/09/06		10.00%		8/04/07		407		407		407		\$74.09		\$5.26
															TOTAL		

LATE INTEREST KEY

RECEIPT DATE - THE DATE USED FOR CLAIM RECEIPT.
RESET DATE - THE DATE THE LAST CLAIM CORRECTION WAS MADE, USED, WHEN PRESENT INSTEAD OF RECEIPT DATE TO CALCULATE THE LATE INTEREST PAYMENT
I-RATE - INTEREST RATE USED.
PAY DATE - THIS IS THE EFFECTIVE PAYMENT DATE FOR THE PAYMENT. (CHECK OR ACH DATE.
IN SYS - MEANS DAYS IN THE SYSTEM. DIFFERENCE BETWEEN RECEIPT DATE AND PAY DATE.
LATE - MEANS THE NUMBER OF DAYS LATE, DAYS IN EXCESS OF STATE MAX DAYS TO PAY.

SOR SAMPLE ONLY

ACCOUNTS RECEIVABLE (A/R) DEFINITIONS

The A/R page displays details of a claim previously paid and retracted. This page also identifies changes in subscriber liability due to claim adjustments.

- 35 **Status** — The status of the A/R. These include: A (active), P (pending), C (closed), and T (to be closed).
- 36 **Date Entered** — The date that IBC created the A/R.
- 37 **Activated Date** — The date the A/R is to be active.
- 38 **Start Amount** — The starting amount of the A/R.
- 39 **Remaining Balance** — The balance remaining before the A/R is satisfied.
- 40 **Last Active** — The date of the last activity.
- 41 **Source System/Claim Number** — The IBC-generated claim number.
- 42 **Provider Patient Identifier** — The number the provider uses to identify the member within the provider's system(s).
- 43 **Date of Service** — The date(s) that the member received health care services. The first date of service and the last date may be listed if a range is reported.
- 44 **Patient Name** — The name of the member receiving the services.
- 45 **Company Patient Identifier** — The company ID of the member receiving the services.
- 46 **Message** — Explains why the claim was adjusted.
- 47 **Date Taken** — The date the A/R was applied.

- 48 **Amount Taken** — The dollar amount that was applied to the outstanding A/R balance.
- 49 **Running Balance** — The balance of the amount owed on the A/R.
- 50 **Payment Number** — The payment document number that the A/R was collected from. It could be an IBC reimbursement check or a personal check that was sent in from the provider.
- 51 **Bank Code** — A code that allows the provider to identify the type of payment. Note: A PERCK is a bank code indicating the refund check was sent by the provider.

INTEREST STATEMENT DEFINITIONS

The Interest Statement page shows the necessary information regarding interest when a claim is paid late.

- 52 **Claim Paid Late** — Claim number that paid late.
- 53 **Receipt Date** — The date used for claim receipt.
- 54 **Reset Date** — The date used to calculate interest due.
- 55 **Interest Rate** — Interest rate used.
- 56 **Payment Date** — The effective date for the payment.
- 57 **In System** — The date in the system (difference between receipt date and payment date).
- 58 **Late** — Number of days late interest was calculated.
- 59 **Claim Amount** — The amount used to calculate the interest.
- 60 **Interest** — The amount of interest due.



**Independence
Blue Cross**

*SOR: How to Read Your **Facility** Statement of Remittance* was published along with this edition of *Partners in Health Update*.

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

INTRODUCTION

We are excited to announce that effective October 2007, the Statement of Remittance (SOR) will use a new format to report claim payments. We listened to your feedback and worked collaboratively with a group of facility and professional providers to develop a new streamlined SOR.

Highlights of this new SOR include:

- an easy-to-read landscape format;
- remark codes with definitions after each claim to make posting easier for billing offices;
- the inclusion of contact phone numbers on the summary page;
- summaries of inpatient facility claims for ease of posting (when there is only one payment reimbursement);

- suppressed line items on adjustment when changes do not affect payment;
- simplified sorting and subtotalling;
- a redefinition of the *Allowed Amount* column to contain the *Contract Amount*;
- interest amount (if applicable) included with each claim;
- subtotals (by product) on the back of the SOR.

This document provides a detailed overview of the SOR, with concise definitions of the headers, numbers, and remarks that you need to understand to interpret your SOR. Please use this document as a reference tool for your office.

Please contact your Network Coordinator if you have questions regarding these enhancements.

SOR SUMMARY PAGE

The image shows a sample SOR Summary Page and a check. The SOR Summary Page includes the Independence Blue Cross logo, address, and contact information. It features a 'PAYMENT SUMMARY' table with the following data:

NET CLAIM AMOUNT:	\$25,935.52
MONIES DUE AMOUNT TAKEN:	\$1,525.00
LATE PAYMENT INTEREST PAID:	\$130.41
TOTAL AMOUNT DISBURSED:	\$24,540.93

Below the table is an 'ELECTRONIC PAYMENT SUMMARY' box with the following information:

NET CLAIM AMOUNT: \$25,935.52
 TOTAL AMOUNT DISBURSED: \$24,540.93
 THIS PAYMENT HAS BEEN MADE ELECTRONICALLY
 EFFECTIVE ENTRY DATE: 6/06/2007

The check below is a 'SAMPLE CHECK' from Independence Blue Cross, payable to Healthy Hospital, for the amount of \$24,540.93. The check is dated 6/04/2007 and has check number 997777772. It is marked as 'NON-NEGOTIABLE'.

SOR SUMMARY DEFINITIONS

The first page of each SOR is a **Summary Page** that displays addresses, contact information, financial totals, and payment information; i.e., either a check or a summary of the Electronic Funds Transfer (EFT).

- 1 Phone Numbers** — Use the appropriate Provider Services hotline number for specific questions regarding how a claim was paid.
- 2 Net Claim Amount** — The net amount disbursed prior to application of offsets.
- 3 Monies Due Amount Taken** — The amount of offsets applied on the payment.
- 4 Late Payment Interest Paid** — The total of any interest paid for claims paid late.
- 5 Total Amount Disbursed** — The total amount paid.
- 6 Electronic Payment Summary** — If you receive an EFT payment, the summary displays the amount and the effective date.
- 7 Important Messages** — Look for important messages from IBC on the SOR Summary Page.
- 8 Check** — If a check has been issued, it will be attached to the bottom of the summary page.

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SOR DETAIL DEFINITIONS

Each SOR consists of an **SOR Detail** section (which can number several hundred pages) that displays concise information regarding your remittances. Totals are located on the final page of the section.

- 9 **Pay To Box (NPI)** — Identifies the NPI of the provider who will receive the payment.
- 10 **Pay To Box (Check Number)** — Identifies the check number or document number of the payment.
- 11 **Inpatient Claims** — Indicates inpatient claim section.
- 12 **Product Identifier** — Indicates the product in which the member has enrollment (can include PPO, HMO, or Traditional).
- 13 **Dates of Service** — The date(s) that the patient received health care services. The first date of service and the last date may be listed if a range is reported.
- 14 **Procedure/Revenue Code** — Describes the procedure or revenue code for each service. N/A indicates that the payment was summarized on the SOR.
- 15 **Place of Service (POS)** — Describes the location that the service was performed.
- 16 **Total Units** — The number of units for each service.
- 17 **Patient Account Number** — The number used by the provider to identify the member in the provider's system(s).
- 18 **Amount Billed** — The dollar amount charged by the provider for the services rendered.
- 19 **Allowed Amount** — The amount allowed (i.e., contract rate) for each covered service.
- 20 **Member Noncovered** — The dollar amount that is not covered by the member's benefits.
- 21 **Deductible** — The amount of covered expenses paid by the member before the insurance plan will assume any liability.
- 22 **Copayment** — A fixed or set amount that a member pays at the time a service is rendered.
- 23 **Coinsurance** — Percentage of the allowed amount that the member pays after the plan pays.
- 24 **Member Responsibility** — The amount owed by the member to the provider.
- 25 **Remark Codes** — Codes for payment explanations.
- 26 **Amount Paid** — The amount paid to the provider.
- 27 **DRG** — A payment used to determine reimbursement for facility providers by classifying inpatient services into groups based on diagnosis, procedures, age/sex of the patient, and the presence of complications.
- 28 **Explanation of Remarks** — Provides the code and definitions of each payment explanation after each claim.
- 29 **Provider Noncovered** — The amount that is not covered according to the provider contract.
- 30 **Penalty** — Type of cost-sharing that insurance plans assess resulting in a reduction of payment.
- 31 **Other Insurance Payment** — The dollar amount paid by the primary insurance coverage.
- 32 **Source System/Claim Number** — In cases where a claim is adjusted under a secondary claim number, both claim numbers will display separated by a comma.
- 33 **Interest** — The interest amount (if due).
- 34 **Outpatient Claims** — Indicates outpatient claim section.
- 35 **Product Totals** — The type of coverage the member has is listed and then totaled at the end of the SOR.
- 36 **POS Key** — Defines the Place of Service code (see definition #15).

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ACCOUNTS RECEIVABLE (A/R) DETAIL PAGE

CHECK NO 777777771 DATE 6/04/2007 PAGE X OF XX
THIS IS NOT A BILL

RECIPIENT ID: 9991234888 SUFFIX: 8000
NAME: HEALTHY HOSPITAL

STATEMENT: MONIES DUE OPEN ITEMS, BALANCES, TRANSACTIONS
(STATUS: T - TO BE CLOSED)

ENTERED	ACTIVATED	START AMOUNT	REMAINING BAL	LAST ACTIVE
06/03/07	06/03/07	1,525.00	0.00	06/04/07

SS-CLAIM NUMBER (PH) 1533533333331
PROVIDER PATIENT ID: 4444444444
DATE OF SERVICE: 8/04/2006
PATIENT NAME: A - PATIENT
COMPANY PATIENT ID: 4444444444

BENEFITS ARE NOT APPROVED. THE PATIENT HAS NOT ELIGIBLE FOR BENEFITS AT THE TIME THE SERVICE WAS PROVIDED.

ACTIVITY TO DATE:

DATE TAKEN	AMOUNT TAKEN	RUNNING BAL	PAYMENT NUMBER
06/04/07	1,393.48	171.52	777777771
06/04/07	171.52	0.00	777777771
TOTAL	1,525.00	0.00	

BANK CODE BC

STATEMENT OF MONIES DUE - KEY

DATE TAKEN - DATE WHEN MONEY DUE WAS TAKEN FROM A PAYMENT BEING MADE.
AMOUNT TAKEN - AMOUNT TAKEN, CANNOT EXCEED PAYMENT AMOUNT.
RUNNING BALANCE - AMOUNT STILL DUE AFTER TAKEN AMOUNT.
PAYMENT NUMBER - IDENTIFICATION OF PAYMENT, CHECK NUMBER OR ACH ID.
BANK CODE - THIS IS THE DOCUMENT AFFECTED BY THE ACTIVITY.

SOR SAMPLE ONLY

INTEREST STATEMENT PAGE

CHECK NO 777777771 DATE 6/04/2007 PAGE X OF XX
THIS IS NOT A BILL

RECIPIENT ID: 9991234888 SUFFIX: 8000
NAME: HEALTHY HOSPITAL

LATE CLAIM PAYMENT INTEREST PAID

CLAIM PAID LATE	RECEIPT DATE	RESET DATE	I-RATE	PAY DATE	IN SYS	LATE	CLAIM AMOUNT	INTEREST
2177777777777	3/09/07		10.000	6/04/07	88	43	\$11,070.00	\$130.41
TOTAL							\$11,070.00	\$130.41

LATE INTEREST KEY

RECEIPT DATE - THE DATE USED FOR CLAIM RECEIPT.
RESET DATE - THE DATE THE LAST CLAIM CORRECTION WAS MADE. USED, WHEN PRESENT, INSTEAD OF RECEIPT DATE TO CALCULATE THE LATE INTEREST PAYMENT.
I-RATE - INTEREST RATE USED.
PAY DATE - THIS IS THE EFFECTIVE PAYMENT DATE FOR THE PAYMENT. (CHECK OR ACH DATE).
IN SYS - MEANS DAYS IN THE SYSTEM. DIFFERENCE BETWEEN RECEIPT DATE AND PAY DATE.
LATE - MEANS THE NUMBER OF DAYS LATE. DAYS IN EXCESS OF STATE MAX DAYS TO PAY.

SOR SAMPLE ONLY

ACCOUNTS RECEIVABLE (A/R) DEFINITIONS

The A/R page displays details of a claim previously paid and retracted. This page also identifies changes in subscriber liability due to claim adjustments.

- 37 **Status** — The status of the A/R. These include: A (active), P (pending), C (closed), and T (to be closed).
- 38 **Date Entered** — The date that IBC created the A/R.
- 39 **Activated Date** — The date the A/R is to be active.
- 40 **Start Amount** — The starting amount of the A/R.
- 41 **Remaining Balance** — The balance remaining before the A/R is satisfied.
- 42 **Last Active** — The date of the last activity.
- 43 **Source System/Claim Number** — The IBC-generated claim number.
- 44 **Provider Patient Identifier** — The number the provider uses to identify the member within the provider's system(s).
- 45 **Date of Service** — The date(s) that the member received health care services. The first date of service and the last date may be listed if a range is reported.
- 46 **Patient Name** — The name of the member receiving the services.
- 47 **Company Patient Identifier** — The company ID of the member receiving the services.
- 48 **Message** — Explains why the claim was adjusted.
- 49 **Date Taken** — The date the A/R was applied.

- 50 **Amount Taken** — The dollar amount that was applied to the outstanding A/R balance.
- 51 **Running Balance** — The balance of the amount owed on the A/R.
- 52 **Payment Number** — The payment document number that the A/R was collected from. It could be an IBC reimbursement check or a personal check that was sent in from the provider.
- 53 **Bank Code** — A code that allows the provider to identify the type of payment. Note: A PERCK is a bank code indicating the refund check was sent by the provider.

INTEREST STATEMENT DEFINITIONS

The Interest Statement page shows the necessary information regarding interest when a claim is paid late.

- 54 **Claim Paid Late** — Claim number that paid late.
- 55 **Receipt Date** — The date used for claim receipt.
- 56 **Reset Date** — The date used to calculate interest due.
- 57 **Interest Rate** — Interest rate used.
- 58 **Payment Date** — The effective date for the payment.
- 59 **In System** — The date in the system (difference between receipt date and payment date).
- 60 **Late** — Number of days late interest was calculated.
- 61 **Claim Amount** — The amount used to calculate the interest.
- 62 **Interest** — The amount of interest due.