# CHAPTER 6: BILLING AND PAYMENT

## UNIT 1: GENERAL CLAIM SUBMISSION GUIDELINES

### IN THIS UNIT




What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

# 6.1 INTRODUCTION TO CLAIM SUBMISSION

**Overview**

In today's business world, there are no requirements to submit claims on paper. Electronic transactions and online communications have become integral to health care. In fact, Highmark's claim system places higher priority on processing and payment of claims filed electronically.

This unit provides guidelines that apply to both electronic and paper claim submissions and is applicable to **both professional and facility providers**.

**Required formats**

Use the table below to determine the required format for submitting claims:

| If you submit... | Then use these formats... | |
|---|---|---|
| **Electronically** | Professional | ASC X12N 837 Health Care Claim: Professional Transaction Version 005010 ("837P") |
| | Facility | ASC X12N 837 Health Care Claim: Institutional Transaction Version 005010 ("837I") |
| **On paper** | Professional | 1500 Health Insurance Claim Form ("1500 Claim Form"), Version 02/12 |
| | Facility | UB-04 (CMS 1450) Institutional Claim Form |

**Note:** If you are using paper forms, please submit the **original** red claim form. Photocopies or outdated versions of the 1500 or UB-04 forms will not be accepted and will be returned to the provider.

**REMINDER: Report appropriate place of service on all claims**

Providers are required to report the most appropriate place of service on claim submissions. To ensure proper processing and reimbursement for your claims, please make sure you are accurately selecting the appropriate Place of Service (POS) code for all claims submitted.

**Note:** Please reference **Chapter 2.5: Telemedicine Services** for guidelines for reporting place of service for virtual visits and other telemedicine services.

**FOR MORE INFORMATION**

For information specific to submitting claims electronically, please see **Chapter 6.2: Electronic Claim Submission**.

For claim reporting tips and guidelines specific to professional providers or facility providers, please see the applicable unit:

- Facility: **Chapter 6.3: Facility (UB-04/837I) Billing**
- Professional: **Chapter 6.4: Professional (1500/837P) Reporting Tips** and **Chapter 6.5: 1500 Claim Form Guidelines**

# 6.1 CLEAN CLAIMS

**Definitions**

A **clean claim** is defined as a claim with no defect or impropriety and one that includes all the substantiating documentation required to process the claim in a timely manner. The core data required on a claim to make it clean are outlined in this section and the next section.

**Unclean claims** are those claims where an investigation takes place outside of the corporation to verify or find missing core data. An example of this is when a request is sent to the member for information regarding coordination of benefits. This may require obtaining a copy of an Explanation of Benefits (EOB) from the member's other carrier. Claims are also considered unclean if a request is made to the health care professional for medical records. Claim investigations can delay the processing of the claim.

**IMPORTANT!**

**You must provide us with the required information in order for the claim to be eligible for consideration as a "clean claim." If changes are made to the required data elements, this information shall be provided to network providers at least thirty (30) days before the effective date of the changes.**

**NUBC and NUCC resources available**

A description of the data elements necessary to ensure that facility claims are without "defect or impropriety" can be found in the current **Official UB-04 Data Specifications Manual**. This manual is available from the National Uniform Billing Committee (NUBC) and can be found on their website at **nubc.org**.

For professional services, please see the current **1500 Health Insurance Claim Form Reference Instruction Manual** from the National Uniform Claim Committee (NUCC) and available at **nucc.org**.

# 6.1 TIMELY FILING REQUIREMENTS

**What is timely filing?**

Timely filing is a Highmark requirement whereby a claim must be filed within a certain time period after the last date of service relating to such claim or the payment/denial of the primary payer, or it will be denied by Highmark.

What Is My Service Area?

**Timely filing policy**

**Any claims not submitted and received within the time frame as established within your contract will be denied for untimeliness.** If timely filing is not established within your contract, claims must be received within 365 days of the last date of service in Pennsylvania and West Virginia, and within 120 days of the date of service in Delaware, unless the member's policy provides for a different period.

If Highmark is the secondary payer, claims must be submitted with an attached Explanation of Benefits (EOB) and received within the same timely filing time frames as when Highmark is primary; however, the time frame is **based on the primary payer's finalized or payment date**, as shown on the EOB attachment.

**Highmark as secondary payer**

When Highmark is a secondary payer, a provider must submit a claim within the timely filing time frames indicated above and attach an EOB to the claim that documents the date the primary payer adjudicated the claim. Secondary claims not submitted within the timely filing period will be denied and both Highmark and the member held harmless. Electronically-enabled providers should submit secondary claims electronically using the proper Claim Adjustment Segment (CAS) code segments.

When it is known or there is a reason to believe that other coverage exists, claims are not paid until the other carrier's liability has been investigated. Highmark may send a letter/questionnaire to the covered person.

- If the covered person responds to the letter/questionnaire indicating that he/she is covered by additional policies, the records are marked to indicate that the other carrier information is required to complete claims processing when the other carrier's policy is primary.
- If the covered person does not respond promptly to Highmark's request for information, Highmark will deny claim payment using a remark code indicating the covered person is responsible. The provider may seek reimbursement from the covered person.

**Note:** Federal Employee Program (FEP) claims are not denied but are pended until a response is received from the covered person. Highmark will not provide benefits for these FEP claims until a response is received.

# 6.1 PROMPT PAYMENT REQUIREMENTS

What Is My Service Area?

**Pennsylvania**

The Prompt Payment Provision of Pennsylvania's Act 68 of 1998 stipulates that health insurers pay "clean claims" within forty-five (45) days of receipt. The 45-day requirement only begins once all of the information needed to process the claim is obtained. The legislation mandates that interest penalties are to be paid to providers for claim payments issued more than forty-five (45) days from the receipt of the claim.

The following types of claims are excluded from the interest penalty requirement:

- Rejected (zero-paid) claims
- Voided claims
- Adjusted claims
- Administrative Services Only (ASO Accounts)
- Federal Employee Program claims
- BlueCard ITS home claims
- Claims with Provider Submission errors
- Claims for which the interest payment is calculated to be less than two dollars ($2)

Interest penalty payments are calculated on the basis of 10% per annum interest and the number of penalty days. **Penalty days** are the number of days beyond the forty-five (45) day parameter, which were required for the processing of the claim.

The formula for calculating Act 68 interest penalty payments is as follows:

[(annual interest % / payment days in a year) **x** Amount paid on the claim] **x** Penalty Days

**OR**

[(.10/365) **x** Amount paid on the claim] **x** Penalty Days

Interest payments will appear on the remittance line for each claim to which they apply, and will be totaled for each segment of the remittance (e.g., Regular Utilization). The field titled "Interest Calc" on the Claim Detail page displays any prompt payment penalty interest that may apply to a particular claim. The interest information is also reported in the 835 Electronic Remittance.

Highmark consistently processes claims well within the 45-day requirement. In fact, clean claims submitted electronically receive priority processing and are finalized within 7 to 14 days. With this in mind, we encourage you to submit all claims electronically to take advantage of the faster processing.

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# 6.1 PROMPT PAYMENT REQUIREMENTS, Continued

**Delaware**

Delaware Insurance Regulation 1310, Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services, requires that health insurers pay "clean claims" within thirty (30) days of receipt. A clean claim is defined as a paper or electronic claim submitted on the appropriate form which includes data for all relevant fields provided in the format called for by the form. The regulation affords an additional time period when more information is needed to adjudicate the claim. The 30-day requirement begins when Highmark Delaware receives a clean claim.

What Is My Service Area?

**West Virginia**

The Ethics and Fairness In Insurer Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the "Prompt Pay Act" ("the Act"), applies to health insurance contracts insured by Highmark West Virginia, with certain exceptions. For claims subject to the Act, Highmark West Virginia adheres to the standards for processing and payment of claims established by the Act.

Highmark West Virginia will generally either pay or deny a clean claim subject to the Act within forty (40) days of receipt if submitted manually, or thirty (30) days if submitted electronically. For clean claims subject to the Act that are not paid within 40 days, Highmark West Virginia will pay interest, at the rate of 10 percent (10%) per year, on clean claims, accruing after the 40th day. We will provide an explanation of the interest assessed at the time the claim is paid.

For more detailed information, please see the next section of this unit, **West Virginia Prompt Pay Act**.

# 6.1 WEST VIRGINIA PROMPT PAY ACT

What Is My Service Area?

**Applicability**

The Ethics and Fairness In Insurance Business Practices Act, W.Va. Code §33-45-1 et seq.,commonly referred to as the "Prompt Pay Act" ("the Act"), applies to health insurance contracts insured by Highmark West Virginia, with certain exceptions. For claims subject to the Act, Highmark West Virginia adheres to the standards for processing and payment of claims established by the Act. These standards are summarized in this section of this unit or are addressed in other locations of this manual. The Act does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To providers outside of West Virginia;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, Medicare Supplemental, and the West Virginia Public Employees Insurance Agency (PEIA);
- To most self-funded plans where Highmark West Virginia acts as a third party administrator;
- To BlueCard® claims;
- To claims that are not covered under the terms of the applicable health plan (e.g., Workers' Compensation exclusions);
- When there is a good faith dispute about the legitimacy of the amount of the claim;
- When there is a reasonable basis, supported by specific information, that a claim was submitted fraudulently or with material misrepresentation; or
- Where Highmark West Virginia's failure to comply is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond our reasonable control.

**Payment of clean claims**

Highmark West Virginia will generally either pay or deny a clean claim subject to the Act within forty (40) days of receipt if submitted manually, or thirty (30) days if submitted electronically, except in the following circumstances:

- Another payer or party is responsible for the claim;
- We are coordinating benefits with another payer;
- The provider has already been paid for the claim;
- The claim was submitted fraudulently; or
- There was a material misinterpretation in the claim.

A **clean claim** means a claim: (1) that has no material defect or impropriety, including all reasonably required information and substantiating documentation to determine eligibility or to adjudicate the claim; or (2) with respect to which Highmark West Virginia has not timely notified the person submitting the claim of any such defect or impropriety in accordance with the information in "Requests for additional information."

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# 6.1 WEST VIRGINIA PROMPT PAY ACT, Continued

**Record of claim receipt**

Highmark West Virginia maintains a written or electronic record of the date of receipt of a claim. The person submitting the claim may inspect the record on request and may rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim.

If we fail to maintain such a record, the claim will be considered to be received three (3) business days after it was submitted, based upon the written or electronic record of the date of submittal by the person submitting the claim.

What Is My Service Area?

**Requests for additional information**

For claims subject to the Act, if Highmark West Virginia reasonably believes that information or documentation is required to process a claim or determine if it is a clean claim, then we will:

- Request such information within thirty (30) days after receipt of the claim;
- Use all reasonable efforts to ask for all desired information in one request;
- If necessary, make only one additional request for information;
- Make such additional request within fifteen (15) days after receiving the information from the first request; or
- Make the second request only if the information could not have been reasonably identified at the time of the original request or if there was a material failure to provide the information initially requested.

Upon receipt of the information requested, we will either pay or deny the claim within thirty (30) days.

We cannot refuse to pay a claim for covered benefits if we fail to request needed information within thirty (30) days of receipt of the claim, unless this failure was caused in material part by the person submitting the claim. Highmark West Virginia is not precluded from imposing a retroactive denial of payment of such a claim, unless this denial would be in conflict with the Act's standards on retroactive denials.



**Interest**

For clean claims subject to the Act that are not paid within forty (40) days, Highmark West Virginia will pay interest, at the rate of ten percent (10%) per year, on clean claims, accruing after the fortieth (40th) day. We will provide an explanation of the interest assessed at the time the claim is paid.

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# 6.1 WEST VIRGINIA PROMPT PAY ACT, Continued

What Is My Service Area?

**Limitation on denial of claims where authorization, eligibility, and coverage verified**

Under the terms of its health plan contracts, Highmark West Virginia will reimburse for a health care service only if:

- The service is a covered service under the member's plan;
- The member is eligible on the date of service;
- The service is medically necessary; and
- Another party or payer is not responsible for payment.

If Highmark West Virginia advises a provider or member in advance of the provision of a service that: (1) the service is covered under the member's plan; (2) the member is eligible; **AND** (3) via pre-certification or pre-authorization, the service is medically necessary, then we will pay a clean claim under the Act for the service unless:

- The claim documentation clearly fails to support the claim as originally pre-certified or pre-authorized;
- Another payer or party is responsible for the payment;
- The provider has already been paid for the service;
- The claim was submitted fraudulently or the pre-certification or pre-authorization was based in whole or material part on erroneous information provided by the provider, member, or other person not related to Highmark West Virginia;
- The patient was not eligible on the date of service and Highmark West Virginia did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;
- There is a dispute regarding the amount of the charges submitted; or
- The service provided was not a covered service and Highmark West Virginia did not know, and with the exercise of reasonable care could not have known, at the time of verification that the service was not covered.



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# 6.1 WEST VIRGINIA PROMPT PAY ACT, Continued

**Retroactive denials**

Under the Act, Highmark West Virginia may retroactively deny an entire previously paid claim insured by Highmark West Virginia for a period of one (1) year from the date the claim was originally paid. The Act and its one-year time limit does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To contracted providers outside of West Virginia;
- To claims paid under an ERISA self-funded plan;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, and PEIA;
- When a good faith dispute about the legitimacy of the amount of the claim is involved (e.g., disputed audit findings during the resolution process);
- Where Highmark West Virginia's failure to comply with the time limit is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond its reasonable control (e.g., fire, pandemic flu);
- Where the provider is obligated by law or other reason to return payment to Highmark West Virginia or a Highmark West Virginia member (e.g., Unclaimed Property Act);
- To BlueCard claims; or
- To claims that are not covered under the terms of the applicable health plan (e.g., Workers' Compensation exclusions).

What Is My Service Area?

**Provider recovery process**

Under the Act, upon receipt of a retroactive denial, the provider has forty (40) days to either: (1) notify Highmark West Virginia of the provider's intent to reimburse the plan; or (2) request a written explanation of the reason for the denial.

Upon receipt of an explanation, a provider must: (1) reimburse Highmark West Virginia within thirty (30) days; or (2) provide written notice that the provider disputes the denial. The provider should state reasons for disputing the denial and include any supporting information or documentation.

Highmark West Virginia will notify the provider of its final decision within thirty (30) days after receipt of the provider's notice of dispute. If the retroactive denial is upheld, the provider must pay the amount due within thirty (30) days or the amount will be offset against future payments.

# 6.1 WEST VIRGINIA SELF-FUNDED ACCOUNTS

**Policy**

Highmark West Virginia acts **only** as a third-party administrator for a self-funded benefit plan (i.e., the benefits are not insured by Highmark West Virginia and our services are administrative only). We shall not be required to pay a provider's claim for services rendered to a member of the self-funded plan unless and until the self-funded plan pays or reimburses Highmark West Virginia for the amount of the claim and the administrative cost to process and pay the claim. Highmark West Virginia does not insure, underwrite, or guarantee the responsibility or liability of any self-funded plan to provide benefits or to make or administer payments.

If a self-funded plan fails to provide payment or reimbursement to Highmark West Virginia to fund claims (whether such claims have been paid already by Highmark West Virginia or not), then a provider shall not hold Highmark West Virginia liable, but must look to the self-funded plan or the patient for payment. Highmark West Virginia may demand the return of any payment to the provider, or may set off against amounts owed to the provider, for any claims for which a self-funded plan fails to make payment or reimbursement to Highmark West Virginia.

**Identifying members**

Member ID cards identify members of self-funded accounts. Providers may contact the telephone number on the back of the card to inquire about the current eligibility status of the member, or current funding status of the self-funded account.

What Is My Service Area?

**Special circumstances for terminated accounts**

Upon termination of a self-funded group, Highmark West Virginia will continue to process claims for a period of time as specified in the terminated self-funded account's contract. This is otherwise referred to as a "run-out period." Often the run-out period is less than twelve (12) months, and claims received after this period will be denied.

# 6.1 NEW PATIENT VS. ESTABLISHED PATIENT

**Overview**

Certain evaluation and management (E&M) Current Procedural Terminology (CPT®) codes distinguish between new and established patients. New patient visits are reported with procedure codes 99201, 99202, 99203, 99204, or 99205. Once the provider establishes a new patient, subsequent visits should be billed with 99211, 99212, 99213, 99214, or 99215.

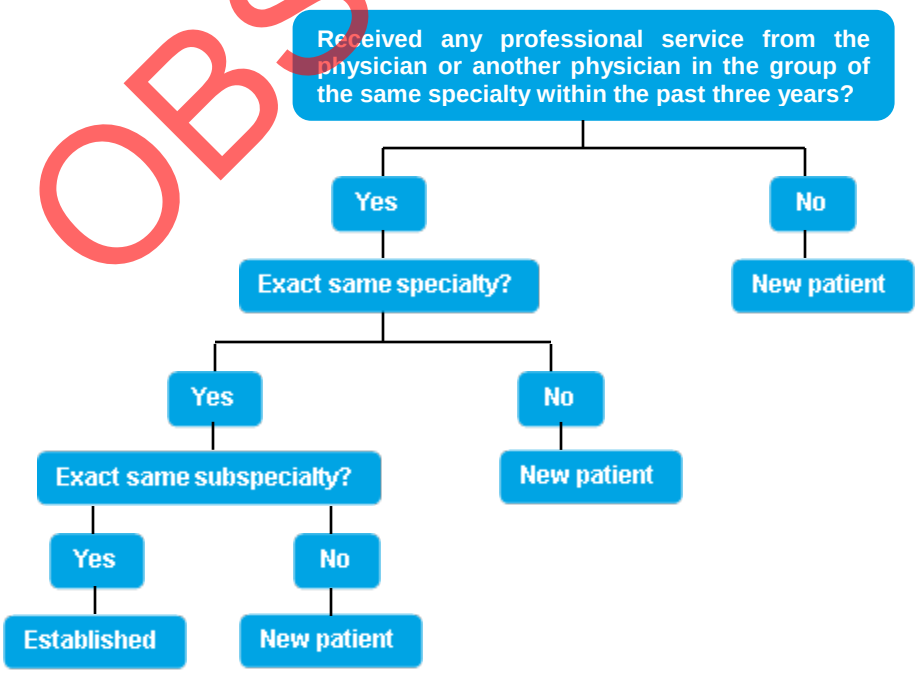
**CPT guidelines for new vs. established patients**

The 2015 CPT guidelines define new and established patients according to the "three-year" rule.

- A new patient is "one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."
- An established patient is "one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."

**CPT Decision Tree for New vs. Established Patients**

The "Decision Tree for New vs. Established Patients" from the CPT E/M Services Guidelines is reproduced here and can be used to help you determine if a patient is new or established.



# 6.1 SERVICE FACILITY LOCATION

**Overview**

**Providers are required to report all locations to Highmark so they can be properly enumerated in our system.** For professional providers, this includes all practice locations, while facilities must report all off-campus locations. When submitting claims, the **actual location where services were delivered must always be reported** to avoid unnecessary processing delays, claim denials, or refund requests.

The **Service Facility Location** field on a claim is used to report the physical location where the services were performed. Highmark requires professional and facility providers to always complete the Service Facility Location when the location where services were rendered differs from the billing address being reported on the claim **or** from the main facility location (e.g., services delivered at a hospital's off-site outpatient surgery center).

It is also important to complete the Service Facility Location field to easily locate your patients' medical records when necessary. Highmark requests records for Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality improvement activities. Identifying the place where services are rendered eliminates unnecessary calls to provider offices to locate medical records.

**IMPORTANT!**

A physical street address **must** be reported for the Service Facility Location -- a P.O. Box or lock box will not be accepted.

**Professional claims (837P/1500)**

The Service Facility Location is reported on professional claims as follows:

- Electronic 837P: **Loop 2310C**
- Paper 1500 claim form: **Item# 32 a, b, c**

For additional information for completing Item #32 on the 1500 claim form, please see the manual's **Chapter 6.5: 1500 Claim Form Guidelines**.

**Facility claims (837I /UB-04)**

Facilities report the Service Facility Location as follows:

- Electronic 837I: **Loop 2310E**
- Paper UB-04 claim form: **Form Locator 01**

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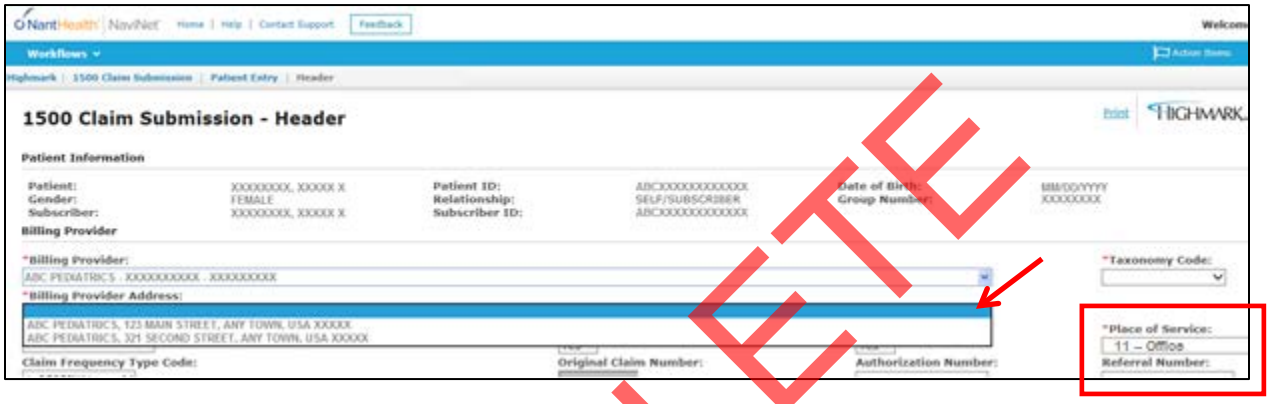
# 6.1 SERVICE FACILITY LOCATION, Continued

**NaviNet® 1500 claim submission**

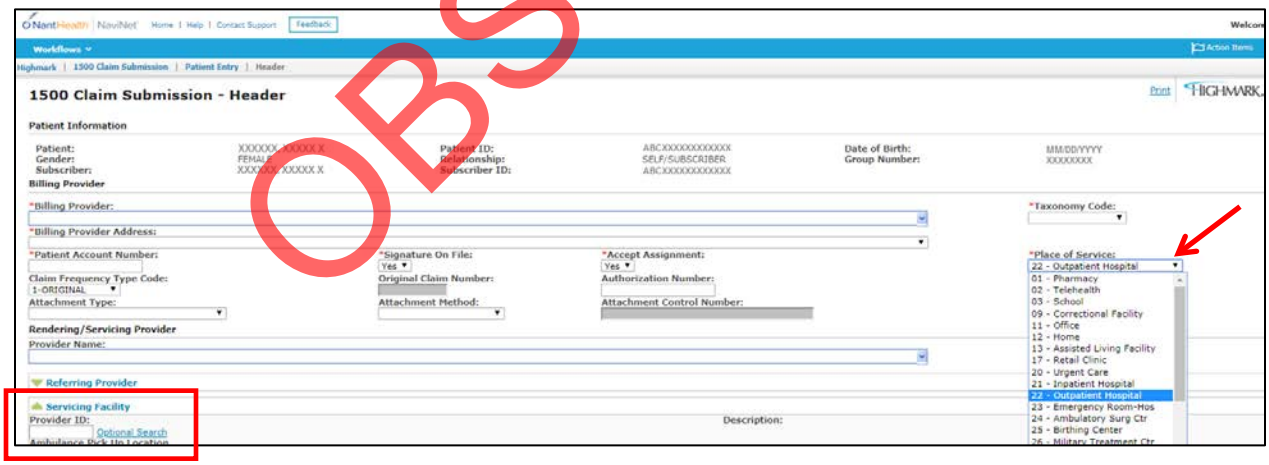
In the NaviNet 1500 Claim Submission transaction, the field to report the actual location where services were rendered depends on whether the services are provided in one of the practice's office locations or at another location.

If the services were delivered at a practice location and the Place of Service is reported as "Office," the service location is reported by selecting the applicable address from the dropdown options for **Billing Provider Address**.






If the services were provided in a location other than one of the practice's office locations, the applicable **Place of Service** would be selected from the dropdown options (see below), and then the **Servicing Facility** field would be completed to identify the Service Facility Location.




**Note:** NaviNet's 1500 Estimate Submission transaction also provides these fields to report the actual location where the services were rendered.

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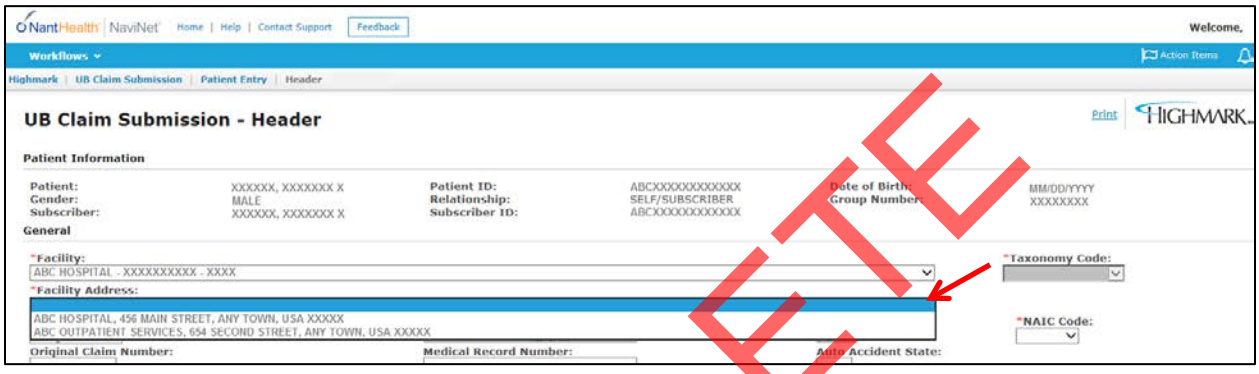
# 6.1 SERVICE FACILITY LOCATION, Continued

**NaviNet UB-04 claim submission**

In NaviNet's UB Claim Submission transaction, the selection of an address from the **Facility Address** field on the Header page is required to specify the actual location where the service was performed (the "Service Facility Location").

**Note:** The **Facility Address** is also a required field in the UB Estimate Submission transaction in NaviNet to specify the actual location where the services were delivered.



# 6.1 DIAGNOSIS CODE REPORTING

**International Classification of Diseases (IDC)**

The International Classification of Diseases (ICD) is a medical code set maintained by the World Health Organization (WHO). It was developed so that medical terms reported by physicians, medical examiners, and coroners can be grouped together for statistical purposes.

**ICD-10 compliance**

**Effective October 1, 2015, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is the standard for reporting patient diagnoses, replacing ICD-9-CM.** ICD-10 provides more specific data than ICD-9 and better reflects current medical practice. The added detail embedded within ICD-10 codes informs health care providers and health plans of patient incidence and history, which improves the effectiveness of case management and care coordination functions. **Highmark will accept only ICD-10-CM diagnosis codes on claims for dates of service October 1, 2015 and after.**

**Please Note:** ICD-10 diagnosis code reporting does not directly affect provider use of the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

**Highest level of specificity required**

Highmark requires you to report the highest level of specificity when reporting diagnosis codes on medical-surgical claim forms.

Since Highmark's claims processing system applies medical payment guidelines based on diagnosis codes, you must report the most appropriate diagnosis code(s) on every claim. The diagnosis must be valid for the date of service reported.

***Document and code all coexisting conditions***

*The Centers for Medicare & Medicaid Services (CMS) instructs providers to code all conditions that coexist at the time of a visit and impact the member's treatment plan or management of their care.*

*Do not report conditions that previously existed but are no longer being treated.*

**Be as accurate as possible**

Highmark will reject your claims for payment if you submit them without complete or accurate diagnosis codes.

***Why blue italics?***

**NaviNet® Diagnosis Code Inquiry**

NaviNet® includes a diagnosis code inquiry that lets you look up diagnosis codes by code or description, and also provides effective dates and end dates for the codes.

# 6.1 REPORTING NATIONAL DRUG CODES

**Converting NDCs from 10-digits to 11-digits**

Many NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10-digit to an 11-digit format requires a strategically placed zero, dependent upon the 10-digit format.

The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted additional "0" is in a **bold font and underlined** in the following example. Note that hyphens indicated below are used solely to illustrate the various formatting examples for NDCs. **Do not use hyphens when entering the actual data in your paper claim form.**

| CONVERTING NDCs FROM 10-DIGITS TO 11-DIGITS | | | | | |
|---|---|---|---|---|---|
| **10-Digit Format on Package** | **10-Digit Format Example** | **11-Digit Format** | **11-Digit Format Example** | **Actual 10-Digit NDC Example** | **11-Digit Conversion of Example** |
| 4-4-2 | 9999-9999-99 | 5-4-2 | **0**9999-9999-99 | 0002-7597-01<br>Zyprexa® 10mg Vial | **0**0002759701 |
| 5-3-2 | 99999-999-99 | 5-4-2 | 99999-**0**999-99 | 50242-040-62<br>Xolair® 150mg vial | 50242**0**04062 |
| 5-4-1 | 99999-9999-9 | 5-4-2 | 99999-9999-**0**9 | 60575-4112-1<br>Synagis® 50mg vial | 6057541120**1** |

# 6.1 REPORTING WORKERS' COMPENSATION RELATED SERVICES

**Introduction**

Workers' compensation insurance covers medical expenses for work-related injuries or illnesses. Highmark is not liable to pay claims for members under these circumstances, unless the services are determined to be ineligible under workers' compensation benefits. Highmark employs several processes to ensure the services provided to our members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

In order for our members' medical services to be paid in a timely manner, network participating providers must assist in our efforts by properly reporting on claim submissions when services were for employment-related conditions or injuries.

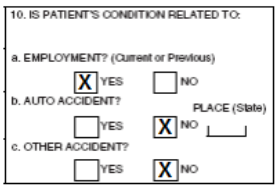
Guidelines are provided below for the additional fields required on claims when reporting services related to workers' compensation on both professional and facility claims.

**Reporting on the 1500 claim form**

Item Numbers 10 and 14 must be completed on the 1500 claim form when reporting professional services related to workers' compensation.

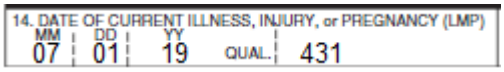
**Item #10 - IS PATIENT'S CONDITION RELATED TO:**

- Enter an "X" in **YES** for **EMPLOYMENT (10a)** to indicate whether one or more of the services reported in Item#24 is for a condition or injury that occurred on the job.
- Place an "X" in NO for 10b and 10c.




**Item #14 – DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP):**

- Enter the date of onset of the work-related illness or the date of injury in 6-digit format (MM|DD|YY).
- Enter qualifier **431** (Onset of Current Symptoms or Illness) to the right of the vertical dotted line.




**Note:** If known, additional information that would assist in the processing of these claims can be included to avoid any unnecessary delays in finalizing the claims (e.g., workers' compensation insurer information or claim denial notice from workers' compensation).

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# 6.1 REPORTING WORKERS' COMPENSATION RELATED SERVICES, Continued

**Reporting on the 837P**

For professional electronic claims (837P), the following crosswalk outlines the required fields on the 837P that correspond to the required fields on the 1500 claim form:

| 1500 FORM LOCATOR | | 837P | | | |
|---|---|---|---|---|---|
| **Item #** | **Locator Description** | **Loop ID** | **Segment/ Data Element** | **Code** | **Electronic Description** |
| **10a** | IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT? | 2300 | CLM11 | EM (Employment) | RELATED CAUSES CODE |
| **14** | DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) | 2300 | DTP01<br>DTP03 | 431<br>D8 (CCYYMMDD) | ONSET OF ILLNESS DATE OR ACCIDENT DATE |

**Reporting on the UB-04 claim form**

For facilities submitting claims for services that are work related and for which workers' compensation may apply, **Locator 31: Occurrence Code and Date** must be completed on the UB-04 (CMS 1450) claim form in addition to all other required fields.

You must enter **Occurrence Code 04** to indicate services are "Accident/Employment Related." And then enter the date of onset of the work-related illness or the date of the work-related accident in 6-digit format (MMDDYY):

| 31 OCCURRENCE CODE | 31 OCCURRENCE DATE | 32 OCCURRENCE CODE | 32 OCCURRENCE DATE | 33 OCCURRENCE CODE | 33 OCCURRENCE DATE | 34 OCCURRENCE CODE | 34 OCCURRENCE DATE |
|---|---|---|---|---|---|---|---|
| 04 | 070119 | 24<br>or<br>25 | 083119<br><br>083119 | | | | |

In addition, either Occurrence Code 24 **or** 25 must be entered to report a denial of the claim by the workers' compensation insurer or the termination of workers' compensation coverage.

- **Occurrence Code 24 = Date Insurance Denied.** Code indicating the date the denial of coverage was received by the health care facility from any insurer.
- **Occurrence Code 25 = Date Benefits Terminated by Primary Payer.** Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.

**Note:** If known, additional information that would assist in the processing of these claims can be included to avoid any unnecessary delays in finalizing the claims (e.g., workers' compensation insurer information or claim denial notice from workers' compensation).

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# 6.1 REPORTING WORKERS' COMPENSATION RELATED SERVICES, Continued

**Reporting on the 837I**

For institutional electronic claims (837I), the table below identifies the required fields that are equivalent to Locator 31 on the UB-04 for entering occurrence codes and corresponding dates for work-related services.

| UB-04 FORM LOCATOR | | 837I | | | |
|---|---|---|---|---|---|
| **Locator** | **Locator Description** | **Loop** | **Segment** | **Code** | **Electronic Description** |
| **31** | Occurrence Code & Date | 2300 | HI01-1<br>HI01-3 | BH (04 & either 24 or 25)<br>D8 (CCYYMMDD) | Occurrence Code/ Date |

**FOR MORE INFORMATION**

To learn more about the processes applied when Highmark members have coverage under another insurer(s), please see **Chapter 6.6: Coordination of Benefits**.

# 6.1 DOCUMENTATION REQUIREMENTS

**Overview**

Highmark requires that patient records document every service submitted for payment. This includes diagnostic tests, medical care, surgery, and any other services eligible for payment by Highmark.* You should not routinely submit this documentation with your claims except in circumstance when required (e.g., when using modifier 22). If documentation is needed, Highmark will request it. Please retain your office records for audit purposes.

Hospital and office records must verify that a service: 1) was actually performed; 2) was performed at the level reported; and 3) was medically necessary. The services billed by the provider must be documented by personal notes and orders in the patient's records.

** In Pennsylvania, regulations issued by the Pennsylvania Board of Medical Education and Licensure support this policy.*

What Is My Service Area?



**Criteria for documentation submission**

Highmark will use this criteria to determine if the provider has met the appropriate documentation requirements:

- Hospital medical visits: The admission and discharge records, doctor's orders, and progress notes should clearly reflect the type, level of care, and medical necessity of treatment billed by the doctor. The records not only should reflect the doctor's personal involvement in treating the patient, but also should reflect and be co-signed by the interns and residents who write the progress notes and order sheets;
- Surgical services: The operative report should indicate the name of the surgeon who performed the service. Minor surgical procedures not requiring an operative note must be documented in the progress notes. Also, the records should indicate the condition or diagnosis that documents the medical necessity for the surgery;
- Consultation: A consultation includes a history and an examination of the patient by a consultant whose services were requested by the attending physician. There should be a written report signed by the consultant. Additionally, the medical necessity for the consultation must be documented;
- Anesthesia: The anesthesia and/or operative report should indicate the name of the person who actually performed the anesthesia service. Anesthesia time units begin when the doctor begins to prepare the patient for induction and ends when the patient may be safely placed under postoperative supervision and the doctor is no longer in personal attendance. The records should reflect the actual time units reported;

*Continued on next page*

# 6.1 DOCUMENTATION REQUIREMENTS, Continued

**Criteria for documentation submission** (continued)

- Medical reports: Office records should contain the patient's symptoms and/or complaints, diagnoses, tests performed, test results and treatment given or planned. In addition, the copies of hospital records should be clear and readable. In cases involving concurrent medical care, the consulting physician should submit these records with the request for review;
- Emergency medical/accident: Claims for emergency medical and emergency accident services always should include a date of onset and a date of service. Emergency medical services should be reported with the appropriate evaluation and management code, the ET (emergency services) modifier, and a diagnosis code that reflects an emergency medical service.

# 6.1 CLAIM STATUS INQUIRIES

**Introduction**

Providers can check the status of a claim by using NaviNet® Claim Status Inquiry or the 276/277 Health Care Claim Status Request and Response transactions.

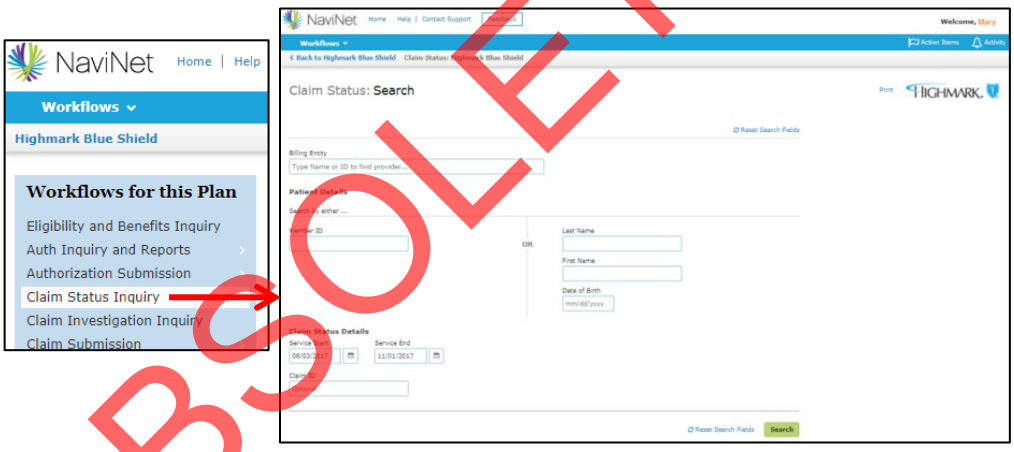
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

Quick Reference

**NaviNet® Claim Status Inquiry**

Claim Status Inquiry lets you view real-time, detailed claims information for any member, whether claims were submitted electronically or on paper. You can track the status of a claim from the start of the adjudication process until the time of payment, or you can look up claims dating back seven years.

To check claim status, select **Claim Status Inquiry** under **Workflows for this Plan** to access the **Search** screen and enter the patient and claim details.




**276/277 -- Health Care Claim Status Request and Response Transaction**

The HIPAA-mandated 276/277 electronic claim status request and response are a paired transaction set -- the 276 transaction is used by the provider to request the status of a claim(s) and the 277 transaction is used by the payer to respond with information regarding the specified claim(s). The response returned by the payer indicates where the claim is in the adjudication process (e.g., pending or finalized). If finalized, detailed information is provided on whether the claim is paid or denied, and if denied or rejected, the reason is included.

Highmark will accept and return 276/277 transactions in Version 5010 format only. These transactions will only be accepted and returned via real-time; trading partners are not able to submit electronic inquiry transactions in a batch mode.

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# 6.1 CLAIM STATUS INQUIRIES, Continued

**276/277 -- Health Care Claim Status Request and Response Transaction** (continued)

Information about the 276/277 transactions can be found in the *EDI Guide,* available on the Electronic Data Interchange (EDI) website. To access the website from the Provider Resource Center, select **CLAIMS, PAYMENT & REIMBURSEMENT**, and then **Electronic Data Interchange (EDI) Services**; or click on the applicable link below to access the applicable site directly:

- Pennsylvania: **highmark.com/edi**
- Delaware: **highmark.com/edi-bcbsde**
- West Virginia: **highmark.com/edi-wv**

Providers in all regions can contact Highmark EDI Services by telephone at **1-800-992-0246.**

What Is My Service Area?

# 6.1 CLAIM INVESTIGATION

**Introduction**

A claim investigation is the ordinary means providers use to communicate their questions regarding pending, paid, or denied claims.

**When claim investigation is appropriate**

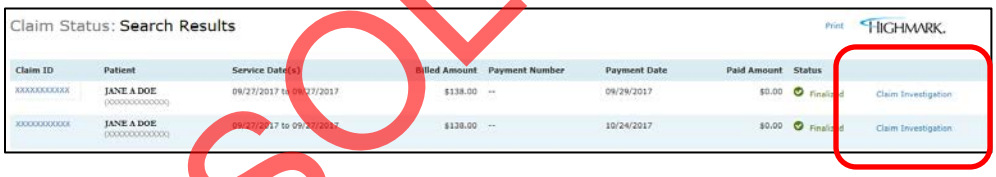
An investigation should be submitted if the provider has a question about the status of a claim. Complete research should be completed by the provider prior to submitting the investigation. A claim investigation is appropriate if any of the atypical situations listed below occurs:

- A claim has been pending for more than forty-five (45) days beyond the received date
- A claim has been paid, but the facility questions the payment amount
- A claim is denied and the facility questions the denial reason

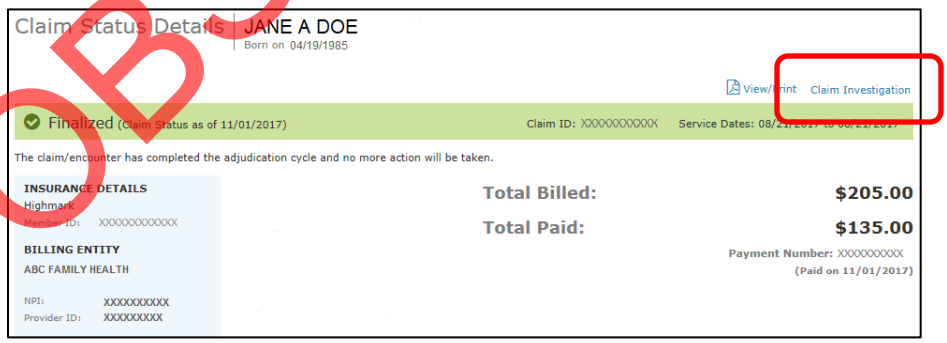
Claim investigations can be launched from NaviNet® Claim Status Inquiry or through the 276/277 Health Care Claim Status Request and Response transactions.

**NaviNet® Claim Investigation**

**Claim Investigation** is available for NaviNet's professional and facility users in two areas within **Claim Status Inquiry**: 1) **Search Results** and 2) **Claim Status Details**.




***or***




When you click on the **Claim Investigation** link, a new window will open (*see next page*).

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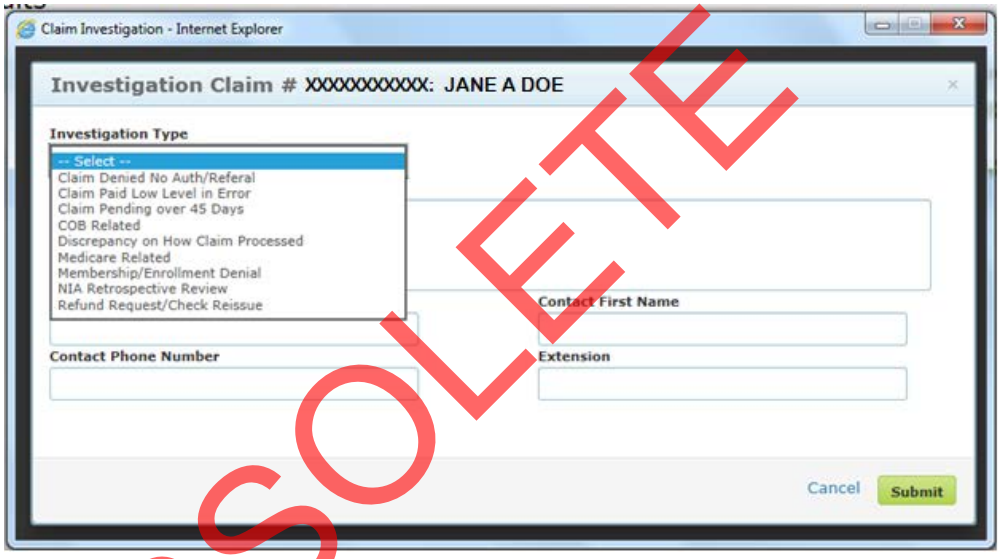
# 6.1 CLAIM INVESTIGATION, Continued

**NaviNet® Claim Investigation** (continued)

The claim number and patient name will be displayed on the claim investigation screen. Select the **Investigation Type** from the choices in the dropdown, and then enter pertinent information in the **Comments** box. Highmark needs enough information to readily address your request about the claim in question. Complete the **Contact** fields, and then click **Submit**. An informational page confirms that the investigation was submitted.

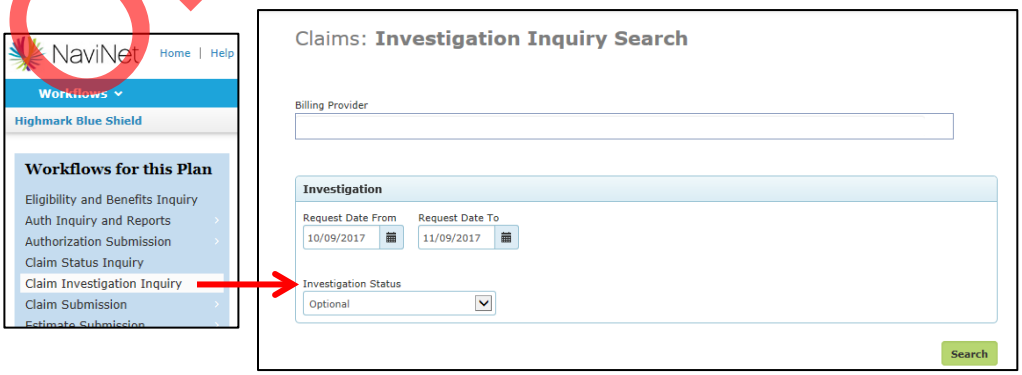
**IMPORTANT!** Please include contact information for Highmark to reach the appropriate person if additional information is needed.






**NaviNet® Claim Investigation Inquiry**

You can check the status of an investigation by using NaviNet's **Claim Investigation Inquiry** under **Workflows for this Plan** on Highmark Plan Central.

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# 6.1 CLAIM INVESTIGATION, Continued

**NaviNet® User Guides**

NaviNet User Guides are available for help when submitting claim investigations. To access **User Guides** for both professional and facility providers, select **Help** from the toolbar, and then select the applicable Highmark option for your service area.

These guides provide more detailed instructions for claim investigation submission, including an **Investigation Type Reference Table** that provides the minimum amount of information you must include in the Comments box for each investigation type.

What Is My Service Area?

**276/277 Health Care Claim Status Request and Response transactions**

Claim investigations can also be done using the 276/277 Health Care Claim Status Request and Response electronic transactions. Information about the 276/277 transactions can be found on the Electronic Data Interchange (EDI) website.

To access the EDI Services website from the Provider Resource Center, select **CLAIMS, PAYMENT & REIMBURSEMENT**, and then **Electronic Data Interchange (EDI) Services**; or click on the applicable link below to access the applicable site directly:

- Pennsylvania: **highmark.com/edi**
- Delaware: **highmark.com/edi-bcbsde**
- West Virginia: **highmark.com/edi-wv**

Providers in all regions can contact Highmark EDI Services by telephone at **1-800-992-0246**.

# 6.1 HIGHMARK'S INTERNAL BILLING DISPUTE PROCESS

**Disputes overview**

Any provider that treats a Highmark member has the right to dispute claims payment decisions made by Highmark. **Any claim dispute between a provider and Highmark arising from a provider's request for payment is solely a contract dispute between the provider and Highmark, and does not involve any other party.** Accordingly, it is important to note that the dispute must not be made against the plan through which a member receives benefits. This limitation applies to plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) and/or the Patient Protection and Affordable Care Act of 2010 (PPACA).

Please note that neither plans nor plan sponsors are parties to any contracts with providers. The terms as to which providers are bound by are governed by its contract with Highmark. Such provider contracts are not binding upon any plan or plan sponsor.

**Anti-assignment provisions**

All Highmark insurance policies for members contain anti-assignment provisions. This means that a provider cannot be a "participant" or "beneficiary" or "receive benefits" (covered services) under the terms of a member's plan (whether insured or self-insured). Only members are entitled to receive benefits. **As a result, a provider cannot dispute a claim with benefit plans or plan sponsors in the event a member's benefits are denied in whole or in part.**

**Submitting a billing dispute**

Highmark offers several ways for providers to express dissatisfaction with their claims payment or lack thereof. Network participating providers may:

- Submit a NaviNet® Claim Investigation Inquiry
- Call Provider Services
- Send written correspondence to Customer Service

It is the provider's responsibility to submit all necessary information about the billing dispute and any additional documentation. If Highmark determines there is incomplete information, the provider will be contacted to provide the necessary information.

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# 6.1 HIGHMARK'S INTERNAL BILLING DISPUTE PROCESS, Continued

**Billing dispute process**

Once all documentation is received, a billing dispute is routed to the appropriate department for research and review. A service representative will review the applicable claim(s) and determine whether the claim(s) processed correctly.

Individual departments within Highmark have varying levels of review and will notify the provider at various stages of the review, as applicable. In certain instances, internal billing dispute processes are considered final. In cases where eligibility requirements are met, further billing dispute resolution processes may be available.

No matter the outcome, each provider who submits a billing dispute will receive notification advising them of the outcome and the reason for the decision. Actions will be taken to remedy the billing dispute, if the provider's contention was correct.

**BlueCard®**

Please contact Highmark directly for billing disputes rather than contacting the out-of-area member's Home Plan.

**Unresolved disputes**

PA ONLY

In Pennsylvania, a billing dispute with a health services doctor (as defined in 40 Pa. C.S.A. Section 6302) which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration.

What Is My Service Area?

# 6.1 THE TOP BILLING ERRORS – AND HOW TO AVOID THEM

**Common claims reporting errors** Claims processing experts identified the top ten common errors that cause claims to process incorrectly.

| Some common reporting errors… | CORRECTION |
|---|---|
| Incorrect provider number listed | Generally, the billing provider number is the assignment account, while the performing provider number is the individual practitioner. If practices are unsure which National Provider Identifier (NPI) to use (assignment account/group or individual practitioner/group member), they should contact Highmark Provider Services. |
| Performing provider name and number | The performing practitioner name and practitioner identification number should be reported on the claim when it is different than the billing provider identification number. |
| Invalid place of service codes submitted and/or the facility name and number is not listed | Ensure the correct place of service code is being used. When the place of service is different than the billing provider's address (e.g., Hospital or SNF), ensure a service facility location and identification number are reported. |
| NOC (not otherwise classified) codes listed without descriptions | Descriptions of the service provided must be reported on the claim for NOC codes. |
| Applicable coordination of benefits/other insurance information and/or documentation is not accompanying the claim | Please make an effort to report electronically or attach coordination of benefits/other insurance information |
| Member identification numbers are incomplete | List the complete member identification number including any alpha prefix. |
| Claims are range dated but the number of services do not clearly correspond with the date range (e.g., indication that services were performed 01-01-16 through 01-10-16 but list only five services) | When services span over a period of days, the number of services should correspond on a one-on-one basis if you are range dating (indicating that services span from one date through another date). If they do not correspond on a one-on one basis, you should itemize the services. |
| Submit HCPCS codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2015 with a code that was not in place until 2016 or vice versa) | Report correct procedure codes that are valid for the date of service. |
| Invalid diagnosis code | Report diagnosis codes that are the highest degree of specificity and valid for the date of service. |