

CHAPTER 6: BILLING AND PAYMENT

UNIT 3: FACILITY (UB-04/837I) BILLING

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

6.3 FACILITY BILLING OVERVIEW

Introduction

Highmark requires facility providers to bill electronically via 837 Institutional (837I) electronic transactions. HIPAA-compliant UB Claim Submission is also available in NaviNet®. In some cases, claim submission may be necessary on UB-04 paper claim forms.

[Why blue italics?](#)

Facility Bulletins

In the past, Highmark published Facility Bulletins to communicate policies and procedures to facilities. Although the publication of newly created Facility Bulletins was discontinued in 2015, Facility Bulletins have continued to be available online to providers as resources and for historical reference in all service areas.

Highmark is currently in the process of reviewing all Facility Bulletins to determine whether information is still valid prior to archiving the Facility Bulletins. Information that is still valid will be transitioned to reimbursement policies or to the Highmark Provider Manual, unless it is already available in another resource (e.g., Medical Policy). Once information is transitioned, the bulletins will be end-dated and marked OBSOLETE. The end-dated bulletins will remain accessible on the Provider Resource Center for historical purposes. Communications will be posted to notify providers as bulletins are end-dated and where information that remains current can be located.

Facility Bulletins, *including those that have been end-dated*, are available on the Provider Resource Center by selecting **NEWLETTERS/NOTICES** from the main menu on the left. The *Highmark Provider Manual*, *Reimbursement Policy*, provider newsletters, Special Bulletins, and other communications (e.g., Plan Central Messages) should be referenced for the most up-to-date information.

Billing Highlights



Billing Highlights are available in Pennsylvania to help facilities identify the information from the UB-04 locator fields that are required when billing specific facility type claims. In addition, helpful tips are offered to assist facilities with providing the needed information for each facility type claim submitted to Highmark.

The Billing Highlights are available on the NaviNet® Provider Resource Centers in Pennsylvania -- select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

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FOR MORE INFORMATION

Please see also [Chapter 4.3: Facility-Specific Guidelines](#) that contains information and guidelines specifically for facilities that may also include reporting guidelines (e.g., Observation Services).

6.3 PRESENT ON ADMISSION/ADVERSE EVENTS

Present on Admission (POA)

Highmark requires the submission of Present on Admission (POA) information on inpatient claims for all hospital providers. This applies to **all inpatient acute care hospitals (including critical access hospitals and children's inpatient facilities)** for all claims.

This requirement is designed to identify and prevent additional reimbursement to the provider for situations in which specified conditions occur during the course of an inpatient stay but were not present at the time of admission. This mechanism serves to implement Highmark's policy on hospital-acquired conditions in the inpatient acute care hospital setting.

[Why blue italics?](#)

Potential reduction in payment for Hospital Acquired Conditions (HAC)

Medicare Grouper for all DRG-reimbursed inpatient acute care hospitals, including critical access hospitals for commercial business, features logic that prevents the assignment of a higher MS-DRG to a claim reporting certain conditions not present on admission (when no other condition on the claim would otherwise trigger a higher MS-DRG).

Highmark will also apply a separate methodology and process to potentially **reduce payment to non-DRG reimbursed hospitals** for claims reporting any of the following conditions if not identified as present on admission (in the absence of other complications or major complications on the claims):

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infection-mediastinitis after coronary artery bypass graft (CABG)
- Manifestations of poor glycemic control
- Deep vein thrombosis (DVT) and pulmonary embolism (PE) following certain orthopedic procedures
- Infections after bariatric surgery
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following cardiac implantable electronic device (CIED) procedures
- Iatrogenic pneumothorax with venous catheterization

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6.3 PRESENT ON ADMISSION/ADVERSE EVENTS, Continued

Non-payment for “wrong” surgical events for all hospital providers

Consistent with Centers for Medicare & Medicaid Services (CMS) policy, Highmark will not make payment for the following three “wrong” surgical events:

- The **wrong surgical or other invasive procedure** was performed
- Surgery *or other invasive procedure* was performed on the **wrong body part**
- Surgery *or other invasive procedure* was performed on the **wrong patient**

Reimbursement Policy RP-036

For additional information applicable to Highmark commercial products, please refer to Highmark Reimbursement Policy Bulletin **RP-036: Preventable Serious Adverse Events**.

Reimbursement policies are available on the Provider Resource Center. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the left, and then **Reimbursement Policy**.

[Why blue italics?](#)

Medicare Advantage Medical Policy N-67



In Pennsylvania and West Virginia, please see **Medicare Advantage Medical Policy N-67: Wrong Surgery (NCDs 140.6, 140.7, 140.8)** for additional information for Highmark Medicare Advantage products.

Medicare Advantage Medical Policy is available on the Provider Resource Centers in Pennsylvania and West Virginia. Select **MEDICAL POLICY SEARCH** from the Quicklinks bar across the top of the Provider Resource Center, and then click on **MEDICARE ADVANTAGE MEDICAL POLICIES** in the drop-down menu.

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OBSOLETE

6.3 NATIONAL CORRECT CODING INITIATIVE (NCCI) EDITS

Introduction

The National Correct Coding Initiative (NCCI) edits were developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and reduce paid claim errors resulting from improper coding and inappropriate payments. Highmark began to systematically follow CMS guidelines and apply Medically Unlikely Edits (MUEs), a subset of these edits, effective January 1, 2012.

Highmark applies the NCCI edits on a systematic basis to outpatient facility claims rendered in an acute-care hospital for both commercial and Medicare Advantage business.

Systematic application of NCCI edits

Although Highmark has always required contracted facilities to comply with industry coding standards such as those incorporated in the NCCI edits, it has not systematically applied this logic via claims edits under all reimbursement methods. Effective October 1, 2013, Highmark expanded the application of the NCCI edits to all acute care hospitals for outpatient Commercial and Medicare Advantage facility claims in order to produce more accurate payments and reduce the need for claim adjustments due to clerical or coding errors.

The systematic edits will be applied based on the date of service of the claim submitted.

Quarterly updates

Highmark is unable to implement CMS-driven reimbursement changes (such as changes to the NCCI edits) on the CMS effective date. In some cases, the changes are transmitted to Highmark via its software vendor and cannot be implemented until the vendor has distributed the updated software. Even when a software vendor is not involved, all such changes must be evaluated in light of Highmark contracts and system constraints prior to implementation.

Highmark's implementation of CMS-driven changes to the quarterly version updates to the NCCI edits will therefore occur after CMS's implementation and after appropriate evaluation.

6.3 CLAIM ADJUSTMENTS

Overview To make changes to claims that have already been submitted to Highmark, facility providers are to use Adjustment Bill Types XX7, XX8, or XX5 for claims previously submitted by paper and electronically.

Corrected / adjustment bill types Please follow the specific guidelines provided in the table below for Adjustment Bill Types XX8, XX7, and XX5:

ADJUSTMENT BILL TYPE	WHEN TO UTILIZE	HIGHMARK ACTION
XX5 Late Charges Only	This code is to be used for submitting additional new charges or lines which were identified by the facility after the original claim was submitted (use XX7 for BlueCard®).	Adjust the original claim to include the additional charges.
XX7 Replacement of prior claim	This code is to be used when a specific bill or line has been issued and needs to be re-issued in its entirety. When this code is used, Highmark will operate on the principle that the original bill is null and void and that the information present on this bill represents a complete replacement of the previously issued bill.	Adjust the original claim by overlaying data from XX7 claim onto original claim. The new payment amount or retraction will be processed on the original claim.
XX8 Void/Cancel Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill. Use of XX8 will cause the bill to be completely canceled from the Highmark system.	Void the original claim on the remittance.

Codes used to report adjustment claims on 835 Highmark uses the following codes to report adjustment claims on the 835:

- Claim Adjustment Group and Reason Code **CO129** (“Prior processing information appears incorrect”) will be used to deny the claim.
- Remark Code **N770** (“The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.”) will also be used on these claims.

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6.3 CLAIM ADJUSTMENTS, Continued

Original claim number required

The original claim number is required when submitting adjustment bill types XX5, XX7, and XX8 on claims via NaviNet® UB Claim Submission and HIPAA 837I batch and real-time submissions.

The original claim number should be reported in the **Adjustment Claim Link (ACL)** field.

Exceptions

Although the automated process handles the majority of electronically submitted adjustments, there are certain categories of adjustments that still require manual intervention. Among these are adjustments to previously adjusted claims.

Highmark will make every effort to avoid separation between the retraction and repayment components of these adjustments.

Remittance Advice

The Highmark Remittance Advice informs providers of the amount Highmark will pay for a specific claim. It will also detail both paid and denied claims.

Please refer to [Chapter 6.7: Payment/EOBs/Remittances](#) for specific and detailed information pertaining to the remittance Advice.

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6.3 BILLING OUTPATIENT SERVICES WHEN UNPLANNED INPATIENT ADMISSION IS DETERMINED NOT MEDICALLY NECESSARY

Introduction

For emergency (urgent, unplanned) admissions, the hospital is asked to obtain an authorization within forty-eight (48) hours of the admission or as soon as the necessary clinical information is available.

- If the inpatient admission is authorized, the hospital should follow normal billing protocols and report the emergency room or observation services on the member's inpatient claim.
- If the inpatient admission is not authorized, the hospital should report the services provided as an outpatient claims after deciding not to appeal the inpatient denial or after the denial has not been overturned on appeal.

[Why blue italics?](#)

Claim submissions for outpatient services

Highmark recommends that facilities wait to submit claims until all authorization determinations are made and, if inpatient admission is not authorized, until the facility decides whether to pursue an appeal. When it is determined that inpatient admission is not medically necessary, all outpatient services provided (e.g., emergency, observation) may be billed.

If an inpatient claim was submitted prior to a final determination, the provider can submit a claim for the outpatient services that were provided if the inpatient claim was denied. The provider must first submit an XX8 adjustment claim to void the original inpatient claim, and then a new claim can be submitted for the outpatient emergency or observation services.

If a facility submits an inpatient claim to Highmark without seeking preservice review and the required authorization, the claim will deny. The facility can request a retrospective review and submit the applicable medical records for the claim to be considered for payment. Appeal rights would apply in the event of a medical necessity denial.

Note: Condition code 44 should not be billed to Highmark on an outpatient claim when an inpatient admission has been denied (applies to traditional Medicare only).

Medical record documentation

If billing for outpatient services when it is determined that criteria are not met for inpatient admission, the medical record should clearly support the services actually provided and billed.

6.3 GUIDELINES FOR HIPPS REPORTING

Background

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types.

The Centers for Medicare & Medicaid Services (CMS) requires Health Insurance Prospective Payment System (HIPPS) codes on all Medicare Advantage claims for home health agency and skilled nursing facility providers, effective July 1, 2014.

Requirement

Highmark follows the CMS HIPPS reporting guideline for **both commercial and Medicare Advantage** business. Home health and skilled nursing facility providers are required to submit the applicable HIPPS codes on claims for all commercial and Medicare Advantage Highmark members for dates of service on and after July 1, 2014.

Providers are required to report codes that are valid as of the date of service. Always consult the most current national UB Data Specifications Manual for the most updated list of codes.

This requirement does not change your current reimbursement method. Providers should continue to submit claims according to your contract.

Revenue codes

Please report applicable revenue code that represent the prospective payment mechanism as follows.

PROVIDER TYPE	REVENUE CODE	GUIDELINES
Home Health	0023	This revenue code (and the corresponding HIPPS codes) should be reported in addition to the revenue lines representing the home health service billed by the facility.
Skilled Nursing Facility	0022	This revenue code (and the corresponding HIPPS codes) should be reported in addition to the revenue lines representing the skilled nursing service billed by the facility. Bill the revenue line of 0022 with the appropriate Resource Utilization Group (RUG) code and the Assessment Reference Date (ARD).

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6.3 GUIDELINES FOR HIPPS REPORTING, Continued

HIPPS codes

Ensure the appropriate HIPPS code is reported on all Commercial and Medicare Advantage claim submissions. Generate a new HIPPS code for each home health or skilled nursing episode according to CMS guidelines.

Special considerations when naviHealth assigns the RUG level



naviHealth assigns the appropriate RUG code level for Highmark's Medicare Advantage members receiving skilled rehabilitation therapy. In these scenarios, skilled nursing facilities will not complete the typical Medicare Prospective Payment System (PPS) Assessments.

Skilled nursing facilities should follow the guidelines outlined below when naviHealth assigns the RUG Code level:

- **HIPPS code:** naviHealth will only provide the RUG code level, which should be the first three digits of the HIPPS code.
- **Assessment Indicator (AI):** Skilled nursing facilities should report **60** as the AI for members receiving therapy.
- **Assessment Reference Date (ARD):** When using revenue code 0022, the ARD is reported in locator 31-34 with Occurrence Code 50.
- **Admission Date:** The admission date should be entered for Medicare Advantage members receiving skilled rehabilitation services when naviHealth has assigned the RUG level.

For information on Highmark's partnership with naviHealth for post-acute care management for Highmark Medicare Advantage members, please visit the Provider Resource Center (in Pennsylvania and West Virginia). Select **Care Management Programs** from the main menu on the left, and then click on **Post-Acute Care Management for Medicare Advantage Members**.

Service date

For revenue code 0023, the date of service should equal the date of the first billable service on the claim.

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Units of service

Units of service are required on each separate HIPPS revenue line.

- **For each revenue code 0023:** Units should always equal 1.
- **For each revenue code 0022:** The units for the multiple lines should equal the number of room and board days falling under that HIPPS code.

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6.3 GUIDELINES FOR HIPPS REPORTING, Continued

Billing scenarios The table below illustrates several billing scenarios that may occur when reporting Revenue code 0023:

If the provider reports...	Along with...	Then...
Home health Revenue code 0023	The corresponding HIPPS (HHRG) code, valid as the date of service, in correct format.	Submission should succeed, and the claim will be adjudicated according to the member's benefit plan (barring other issues with the claim).
Skilled nursing Revenue code 0022	The corresponding HIPPS (RUG) code, valid as the date of service, in correct format.	Submission should succeed, and the claim will be adjudicated according to the member's benefit plan (barring other issues with the claim).
Revenue code 0022 or 0023	A HIPPS code not valid as of the date of service, or in the incorrect format.	The claim will fail validation edits and be rejected back to the provider for correction. NaviNet-submitted claims in this situation would appear in the Claims Log.
Revenue code 0022 or 0023	A HIPPS code that does not correspond to the revenue submitted.	The claim will fail validation edits and be rejected back to the provider for correction. NaviNet-submitted claims in this situation would appear in the Claims Log.
Revenue code 0022 or 0023	A HCPCS/CPT code instead of a HIPPS code.	The claim will fail validation edits and be rejected back to the provider for correction. NaviNet-submitted claims in this situation would appear in the Claims Log.
No revenue code 0022 or 0023	A HIPPS code.	This is not an acceptable combination in NaviNet, and the provider will be prompted to correct the code.

**REMINDER:
Check your
Claims Log**

Providers who submit claims electronically via NaviNet® are reminded to check their NaviNet Claims Log regularly to ensure that any claims rejected for these reasons are addressed in a timely fashion.

6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY

Introduction Effective November 1, 2018, Highmark's policy on outpatient services prior to an inpatient admission applies a "three (3) day rule" similar to that of the Centers for Medicare & Medicaid Services (CMS). Such services include, but are not limited to, Emergency Department (ED), Observation (OBS), and Pre-Admission Testing (PAT).

Background According to the CMS three-day rule, also known as the "72-hour rule," **diagnostic services** furnished by an admitting hospital three days prior to, and including the date of the beneficiary's admission, are considered inpatient services and are included in the inpatient payment.

For outpatient non-diagnostic services provided during that time frame, the hospital is permitted to separately bill the services if they are **unrelated** to the inpatient admission. However, if the non-diagnostic outpatient services are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

Highmark's guidelines Under Highmark's guidelines, outpatient services rendered within three (3) days prior to an inpatient admission are considered inpatient services and are included in the inpatient payment when they are performed at the **same** facility for a **related** diagnosis.

Highmark will apply CMS' definition of the three-day window. Per CMS' guidelines, **the "three-day window" includes the day of the inpatient admission as well as the three days prior to the admission.** For example, if a member is admitted as an inpatient to a hospital on Wednesday, then outpatient services **related** to the inpatient admission and provided by the **same** hospital on Sunday, Monday, Tuesday, and Wednesday are billed on the inpatient claim and included in the inpatient payment.

These guidelines apply to Highmark's commercial and Medicare Advantage lines of business (except when the provider agreement states otherwise).

Unrelated diagnosis Please note that when outpatient services have been performed within the designated period prior to an inpatient admission **for an unrelated diagnosis**, those services are not to be included on the inpatient claim. These services should be billed independently.

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6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY, Continued

Billing guidelines

Please refer to the table below for guidelines on billing outpatient services on the inpatient claim **for commercial and Medicare Advantage** members:

SERVICES	If...	Then...
Emergency Department (ED)	A member receives ED services within a 3-day period prior to an inpatient admission to the same facility for a related diagnosis...	all services are billed on the inpatient claim.
Observation	A member receives observation services within a 3-day period prior to an inpatient admission to the same facility for a related diagnosis...	all services are billed on the inpatient claim.
Pre-Admission Testing and Other Outpatient Services	A member receives pre-admission testing or other outpatient services within a 3-day period prior to an inpatient admission to the same facility for a related diagnosis...	all services are billed on the inpatient claim.

Claims review

The admitting and/or principal diagnosis fields on the inpatient claim and the outpatient claims within the three-day period are reviewed in determining if the outpatient services rendered within that period are related to the inpatient admission.

Excluded services (commercial members only)

For members with commercial plans, there are certain outpatient services that are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are not to be included on the inpatient claim and should be billed independently. Applicable services are as follows:

- Chemotherapy and/or Outpatient Surgery:**
 These services should not be included on the inpatient claim if they are not performed on the same day of inpatient admission. If they are performed on the same day as the inpatient admission, they must be included on the inpatient claim.
- Maternity Services:**
 Outpatient diagnostic and/or Emergency Department services for a maternity-related diagnosis provided prior to the inpatient admission should not be included on the inpatient claim.

Note: These policy exclusions are not applicable to Medicare Advantage members.

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6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY, Continued

Professional services (1500/837P)

Preoperative care furnished by a provider employed by the hospital within the three-day time period prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital.

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation even when surgery eventually was necessary. Highmark reserves the right to determine what medical care is acceptable to be reimbursed in these situations (except when the provider agreement states otherwise).

Reimbursement Policy RP-039

For additional information, please refer to Highmark's Reimbursement Policy RP-039, effective November 1, 2018. This policy applies to Highmark's commercial lines of business in all of our service areas and also to Medicare Advantage products in Pennsylvania and West Virginia.

Highmark's reimbursement policies are available on the Provider Resource Center. Select **CLAIMS, PAYMENT AND REIMBURSEMENT** from the main menu on the left, and then choose **Reimbursement Policy** from the available options in the submenu.

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6.3 MODIFIER REQUIRED FOR OFF-CAMPUS OUTPATIENT SERVICES

Requirement Hospitals are required to report **modifier PO** (“Services, procedures, tests and/or surgeries furnished at off-campus provider-based outpatient department”) with every Healthcare Common Procedure Coding System (HCPCS) or CPT (Current Procedural Terminology) code for all outpatient items and services furnished in an off-campus provider-based department of a hospital.

This mandatory billing requirement will help the Centers for Medicare & Medicaid Services (CMS) collect data on the frequency of, type of, and payment for services provided in off-campus provider-based hospital departments. Highmark has adopted this requirement for all lines of business, Commercial and Medicare Advantage, for similar reasons.

Main campus & off-campus defined The main campus of a provider is defined as “the physical area immediately adjacent to the provider’s main building, other area, and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.”

“Off campus” references all other facilities or locations not meeting this requirement that are deemed to be provider based.

Where to report on claims The PO modifier must be reported on your 837I electronic submissions (Loop 2400, SV2 Segment) and on any paper claim submissions (UB-04/CMS 1450 – Locator 44) for services performed at an off-campus provider-based outpatient department.

Reminder: Providers are required to provide the “Service Facility Location” information if it is different than the billing address (Loop 2310 E NM1, N3, and N4 on the 837I version 5010). For more information, see [Chapter 6.1: General Claim Submission Guidelines](#).

6.3 HOME HEALTH AGENCY BILLING HOME INFUSION SERVICES FOR MEDICARE ADVANTAGE

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Billing guidelines



When a Medicare Advantage member is being treated under 60-day Episode of Care and concurrently receiving home infusion services, the proper billing methodology must be used by the home health agency.

If home infusion services are being provided, the existing 60-day Episode of Care must be closed and a new claim for a Partial Episodic Payment (PEP) with a discharge status of “06” must be submitted to Highmark.

Unrelated services



If additional services are provided to the member that are unrelated to the home infusion services, a claim will need to be submitted for those services using the per visit reimbursement methodology.

Note: These additional services will need to be authorized by Highmark Clinical Services.

Infusion services completed



After the home infusion services have been completed, another 60-day Episode of Care can be submitted if the member requires additional home health services.

Note: An additional 60-day Episode of Care will need to be authorized by Highmark Clinical Services.

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6.3 REIMBURSEMENT FOR INPATIENT HOSPICE WHEN DISCHARGE STATUS INDICATES EXPIRED

Overview	Inpatient hospice facilities will receive reimbursement when the member's discharge status indicates expired. This policy applies to commercial products effective with discharge dates on or after August 1, 2014.
Requirement for claim submission	<p>Highmark requires hospice providers to submit the eligible dates of service and the total number of units for inpatient hospice services, including the date of death. Hospice providers must use discharge status codes when submitting claims:</p> <ul style="list-style-type: none"> • 40 – Expired at home • 41 – Expired in a medical facility • 42 – Expired (place unknown)
Extending the authorization to include date of death	If the member has expired and the date of death is not covered by the existing authorization period, the facility must notify Highmark Clinical Services. This is to extend the authorization and enable the payment to be made for the member's expiration date.

Quick Reference

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6.3 DIAGNOSTIC VS. ROUTINE PAP SMEARS

Introduction	These guidelines clarify billing for both outpatient diagnostic pap smears and routine pap smears.
Billing for routine pap smears	If billing for a routine pap smear , only report a routine diagnosis on the claim to ensure that the claim will process correctly.
Billing for diagnostic pap smears	<p>If billing for a diagnostic pap smear as a follow-up to a routine pap smear, and no other services are being reported on the claim, the diagnosis code reported should only be diagnostic and related to the symptom or chief complaint of the patient.</p> <p>Note: If a routine diagnosis code is reported on a claim where the only service being billed is diagnostic, the claim will be viewed as routine and it may be rejected for benefit limitations.</p>
Diagnostic pap smears with routine services	<p>If billing for a diagnostic pap smear and a routine service:</p> <ul style="list-style-type: none"> • Report the diagnosis related to the symptom or chief complaint of the patient for the diagnostic pap smear, and • Also report the routine diagnosis for the routine service provided.

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6.3 REVISED AND DISCONTINUED BILL TYPES FOR HOME HEALTH

Overview

On October 1, 2013, Highmark aligned with the National Uniform Billing Committee's (NUBC) decision to simplify code sets by revising and discontinuing certain bill types for Home Health providers.

Bill types revised or discontinued

The following bill types have been revised and and/or discontinued:

BILL TYPE	Description of outpatient bill types prior to October 1, 2013	Description of outpatient bill types effective October 1, 2013
032X	Inpatient (plan of treatment under Part B only)	Home Health Services under a Plan of Treatment
033X	Outpatient (plan of treatment under Part A, including DME under Part A)	Discontinued
034X	Other (for medical and surgical services not under a plan of treatment)	Home Health Services not under a Plan of Treatment

IMPORTANT!

This requirement does not affect your reimbursement method. Providers should continue to submit claims according to your contract.

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6.3 GUIDELINES FOR SUBMITTING PAPER CLAIMS

Optical Character Recognition (OCR)

Although electronic claim submission is required, you may encounter a situation in which the submission of a paper claim is necessary. If this occurs, **you must always print or type all information on the claim form.** Clear, concise reporting on the form helps us to interpret the information correctly.

Highmark uses an Optical Character Recognition (OCR) scanner for direct entry of claims into its claims processing system. OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and “reads” the printed data, then stores the image for audit purposes. The scanner can read both computer-prepared and typewritten claim forms.

Tips for submitting paper claims

To ensure that your facility's claims are submitted in a format that allows for clear scanning, please observe the guidelines below so that the scanner can “read” and “interpret” the claim data correctly:

- Only use the approved red UB-04 paper claim form (see next page for sample).
- Always send the **original** claim form to Highmark, since photocopies cannot be scanned. If your facility is using a multi-part form, please submit the top sheet, not one of the copies.
- Print the data on the form via computer, or type it within the boundaries of the fields provided on the form. **DO NOT HAND WRITE.**
- Use a print range of 10 or 12 characters per inch (CPI).
- Use black ink only; the scanner cannot read red ink.
- Do not use excessive amounts of correction fluid on the claims.
- Change the print ribbon or cartridge regularly to ensure print readability; light print cannot be read by the scanner.
- Do not use a rubber stamp to print data in any fields of the UB claim form.
- Do not highlight anything on the claim form or any necessary attachments; highlighted information becomes blackened out and is not legible.

Required information

In order to avoid processing and payment delays, please complete the claim form in its entirety. If required information is not present on the claim, Highmark will return the claim to your facility for completion. Under certain circumstances, Highmark may contact the facility to obtain the missing data.

Exception: Major Medical claims

Pennsylvania Western Region facilities are required to submit Major Medical claims via a red UB-04 paper claim (available at nubc.org), rather than electronically.



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6.3 SAMPLE UB-04 CLAIM FORM



Sample UB-04 Click on the Tip Sheet icon for a full-size version of the sample UB-04 claim form.

The image shows a sample UB-04 claim form, which is a standard form used for billing services. A large, red, diagonal watermark reading "OBSOLETE" is overlaid across the entire form, indicating that this version is no longer in use. The form is divided into several sections:

- Header:** Includes fields for patient name, address, and dates.
- Diagnosis Section:** A grid for recording diagnosis codes (ICD-9-CM) with columns for code, date, and description.
- Procedure Section:** A grid for recording procedure codes (CPT) with columns for code, date, and description.
- Charges Section:** A grid for recording charges, including procedure codes, amounts, and units.
- Provider Information:** Fields for provider name, NPI, and other identifying information.
- Administrative Section:** Fields for health plan name, group name, and other administrative details.

 At the bottom right of the form, there is a logo for NUBC (National Uniform Billing Council) and the text "THE SPECIFICATIONS ON THE REVERSE APPLY TO THIS BILLING AND MAKE A COPY (HERE)".