CHAPTER 6: BILLING AND PAYMENT

UNIT 7: PAYMENT/EOBS/REMITTANCES

IN THIS UNIT

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>SEE PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>2</td>
</tr>
<tr>
<td>Payment Methodology for Professional Services</td>
<td>3</td>
</tr>
<tr>
<td>Explanation of Benefits for Medical-Surgical Contracts</td>
<td>6</td>
</tr>
<tr>
<td>Example of Medical-Surgical EOB</td>
<td>8</td>
</tr>
<tr>
<td>Facility Payment Methodology</td>
<td>11</td>
</tr>
<tr>
<td>Facility Remittance Advice</td>
<td>13</td>
</tr>
<tr>
<td>ANSI Claim Adjustment Group and Reason Codes</td>
<td>20</td>
</tr>
<tr>
<td>Overpayments and Refunds <strong>Updated!</strong></td>
<td>22</td>
</tr>
<tr>
<td>Electronic Manual Payments</td>
<td>24</td>
</tr>
<tr>
<td>Payment for FEP Members Over 65</td>
<td>25</td>
</tr>
<tr>
<td>Payment for the Pennsylvania Children’s Health Insurance Program (CHIP) <strong>Updated!</strong></td>
<td>26</td>
</tr>
<tr>
<td>Non-Network Payment Guidelines</td>
<td>28</td>
</tr>
</tbody>
</table>

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. When no symbol is present, the information is relevant to all states.

- **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.
- **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.
- **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.
6.7 OVERVIEW

**Introduction**
This unit addresses payment methodology for both professional and facility provider types, Explanation of Benefits (EOBs), the Facility Remittance Advice, guidance for overpayments and refunds, and special circumstances, such as payment for Federal Employee Program (FEP) members over 65 years of age.

**Highmark reimbursement policies**
Highmark’s reimbursement policies contain general coding and reimbursement guidelines to help you avoid claim denials and receive timely payment. The policies are reviewed regularly and updated as necessary, with new policies added when a need is identified. When a policy is updated, past versions are stored within the Reimbursement Policy Bulletin and accessed by selecting the CLICK HERE FOR HISTORY VERSIONS link that will appear on the top right of the first page of the bulletin.

To access Highmark’s reimbursement policies on the Provider Resource Center, select CLAIMS, PAYMENT & REIMBURSEMENT from the main menu, and then Reimbursement Policy.

**Compliance with the Mental Health Parity and Addiction Equity Act**
In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), Highmark utilizes the same processes, standards, factors and strategies to develop provider reimbursement rates for providers that render medical services, behavioral health services and substance abuse treatment services. If you have questions about MHPAEA, you can email your questions to: HPMeditor@highmark.com

**Value-based reimbursement**
Highmark’s network management methodology also utilizes value-based reimbursement models, performance, and high-value networks and products. This strategy emphasizes efficiency and appropriateness, encourages provider/payer collaboration, and increases cost and quality improvement potential.

Highmark’s value-based reimbursement strategy evaluates providers' ability to deliver the right care at the right time and in the most appropriate setting. Our value-based reimbursement programs place intense focus on care coordination and population health management principles. For more information, please see Chapter 5.7: Value-Based Reimbursement Programs.

**FOR MORE INFORMATION**
Additional information, such as Medical Policy and HCPCS Information, is available under the CLAIMS, PAYMENT & REIMBURSEMENT category on the Provider Resource Center to assist you in billing services for reimbursement from Highmark.
6.7 PAYMENT METHODOLOGY FOR PROFESSIONAL SERVICES

Overview
Highmark uses several mechanisms to reimburse professional providers for services rendered to its members. These mechanisms vary depending on the program in which the member is enrolled.

How to obtain a usual charge profile
A usual charge profile for allowances for specific codes or for frequently reported procedures can be found on NaviNet® (select Allowance from the menu under Workflows for this Plan), or by writing to:

Highmark Blue Shield
Fee Based Pricing and Analysis
P.O. Box 890089
Camp Hill, PA 17089-0089

Please include your provider name, address, and NPI (National Provider Number) on your request.

The fee information will provide the fee-for-service dollar amount allowable for each CPT code. Highmark will not require the participating physician to provide Highmark with billing rates as a precondition to providing fee information. The procedure codes listed represent those most frequently performed by health care professionals in this specialty. Allowances are current as of the date of the report created by this request.

Plan Allowance
The Plan Allowance is based on the reimbursement terms contained in the Member’s Plan Documents as well as their reimbursement amount contained in the fee schedule applicable to the product and provider. In the event that the provider’s charges are less than the plan allowance for a particular service, the fee paid to the provider for such service will not exceed the provider’s charges.

Plan Allowance amounts are updated periodically to respond to changing economic and market conditions. In Pennsylvania, the timing of updates and methodology employed are subject to approval by the Pennsylvania Insurance Department.

Fee-for-service method
Fee-for-service claims are paid using the network fee schedule specific to the service area. For each service, the payment calculation selects the lower of the provider’s billed amount or the Plan Allowance.

Fee-for-service payments may be subject to member program copayments, coinsurance, and deductibles, and according to the terms of the provider’s contract. If the provider’s charge is less than the Highmark Plan Allowance, including any incentive payments if applicable, the provider’s charge will be paid.

Continued on next page
6.7 PAYMENT METHODOLOGY FOR PROFESSIONAL SERVICES, Continued

Premier Blue Shield is Highmark’s statewide selectively contracted network of preferred providers in Pennsylvania. It is not tied to a specific benefits program but supports a variety of Highmark programs.

Premier Blue Shield allowances are based on a fee schedule that emphasizes evaluation and management services. Adjustments to the Premier Blue Shield fee schedule are made, as needed, to assure providers are receiving fair reimbursement – and to assure that members have adequate access to primary care and specialty services.

Premier Blue Shield providers agree to accept Highmark’s allowances as payment-in-full for covered services. Members are responsible for any applicable copayments, deductibles, or coinsurances.

The Premier Blue Shield Network Fee Schedule is available under CLAIMS, PAYMENT & REIMBURSEMENT on the NaviNet® Provider Resource Centers in both the Western and Central Regions in Pennsylvania.

The First Priority Health (FPH) managed care provider network supports the health maintenance organization (HMO) products in the 13-county Northeastern Region of Pennsylvania, including the Children’s Health Insurance Program (CHIP).

There are several reimbursement methodologies available to primary care physicians (PCPs) participating in the FPH network, including capitation, billables, copayments, and fee-for-service reimbursement as more specifically set forth in your FPH participating provider agreement. For more details, please see Chapter 4.1: PCPs and Specialists.

Fee schedules are only available via your secure NaviNet login. After logging into NaviNet, select Resource Center from the Workflows for this Plan menu on Highmark Plan Central. Select CLAIMS, PAYMENT & REIMBURSEMENT from the Provider Resource Center main menu, and then Fee Schedule Information.
6.7 PAYMENT METHODOLOGY FOR PROFESSIONAL SERVICES, Continued

Medicare Advantage claims are paid differently

Providers with a Medicare Advantage contract with Highmark are reimbursed for Medicare Advantage claims in accordance with their contracted rate, which is based on the Medicare fee schedule.

At a minimum, Medicare Advantage programs are required to provide coverage for the services covered by Traditional Medicare. They may also provide additional services and benefits. While a person is a member of Medicare Advantage, services are not paid by Traditional Medicare except for services incurred during a hospice election period and routine costs associated with clinical trials paid by Medicare.
6.7 EXPLANATION OF BENEFITS FOR MEDICAL-SURGICAL CONTRACTS

Overview

An Explanation of Benefits (EOB) statement is sent to network professional providers and to members via postal mail or electronically based on preference. Along with the claim payments, network providers receive an EOB listing all claims processed each week. This EOB lists each patient’s claim separately. Each individual member on the provider’s EOB will also receive an EOB listing the services processed. (See example of a provider EOB later in this unit.)

Regardless of your practice location, all Highmark EOBs are available electronically on NaviNet® by choosing AR Management, and then clicking on the EOB and Remittance option in the fly-out menu.

Electronic EOBs

All new assignment accounts and practitioners who are newly participating with Highmark are automatically enrolled in NaviNet, the free, easy online solution linking physician offices with Highmark and other health plans. They are also automatically enrolled to receive electronic funds transfers and paperless EOB statements.

All network participating providers are required to enroll in NaviNet, Electronic Funds Transfers (EFT), and paperless EOB statements. After becoming NaviNet-enabled, you can enroll in EFT and paperless EOBs through NaviNet’s EFT Attestation and Registration transaction. For more information, please see the manual’s Chapter 3.1: Network Participation Overview (see the section titled “Electronic Transaction Requirements.”)

Non-network providers

Non-network providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-network provider for services performed.

Key information on an EOB

Both the network provider and member EOB contain the following key information:

- Patient name
- Member identification number
- Member name
- Claim number
- Date of service
- Procedure code
- Provider charge
- Highmark Blue Shield/Medicare allowance

Continued on next page
## 6.7 EXPLANATION OF BENEFITS FOR MEDICAL-SURGICAL CONTRACTS, Continued

<table>
<thead>
<tr>
<th>Key information on an EOB (continued)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Non-chargeable amount</td>
<td></td>
</tr>
<tr>
<td>• Member liability amount</td>
<td></td>
</tr>
<tr>
<td>• Other amount</td>
<td></td>
</tr>
<tr>
<td>• Amount applied to deductible</td>
<td></td>
</tr>
<tr>
<td>• Amount applied to co-insurance</td>
<td></td>
</tr>
<tr>
<td>• Amount deducted for coordination of benefits</td>
<td></td>
</tr>
</tbody>
</table>
6.7 EXAMPLE OF MEDICAL-SURGICAL EOB

The first page of the Explanation of Benefits (EOB) provides a summary of the provider’s information and payment summary.
### Claim detail pages

The pages that follow the summary page provide details of the claims associated with the payment.

<table>
<thead>
<tr>
<th>Provider Number: 0987654321</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name: ABC FAMILY HEALTH</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT ACCT #: 123456</th>
<th>PATIENT: JACK PUBLIC</th>
<th>CLAIM NUMBER: 2987654321</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER ID: X0000000000</td>
<td>MEMBER: JOHN Q PUBLIC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAYMENT CODE</th>
<th>PAYMENT</th>
<th>TOTAL ALLOANCE</th>
<th>TOTAL CHARGEABLE AMOUNT</th>
<th>TOTAL CHARGE CODE</th>
<th>MEMBER LIABILITY AMOUNT</th>
<th>MEMBER LIABILITY CODE</th>
<th>OTHER AMOUNT</th>
<th>AMOUNT PAID (C = MEMBER)</th>
<th>MESSAGE CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>00123456</td>
<td>100.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
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<td>123.00</td>
<td>X0000000000</td>
</tr>
<tr>
<td>00234567</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>X0000000000</td>
</tr>
<tr>
<td>00345678</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>X0000000000</td>
</tr>
</tbody>
</table>

**CLAIM SPECIFIC MESSAGE(S):**

We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

<table>
<thead>
<tr>
<th>PATIENT ACCT #: 123456</th>
<th>PATIENT: JOHN Q PUBLIC</th>
<th>CLAIM NUMBER: 2987654321</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER ID: X0000000000</td>
<td>MEMBER: JOHN Q PUBLIC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAYMENT CODE</th>
<th>PAYMENT</th>
<th>TOTAL ALLOANCE</th>
<th>TOTAL CHARGEABLE AMOUNT</th>
<th>TOTAL CHARGE CODE</th>
<th>MEMBER LIABILITY AMOUNT</th>
<th>MEMBER LIABILITY CODE</th>
<th>OTHER AMOUNT</th>
<th>AMOUNT PAID (C = MEMBER)</th>
<th>MESSAGE CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>00123456</td>
<td>100.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>123.00</td>
<td>X0000000000</td>
</tr>
<tr>
<td>00234567</td>
<td>200.00</td>
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<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>200.00</td>
<td>X0000000000</td>
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<tr>
<td>00345678</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>300.00</td>
<td>X0000000000</td>
</tr>
</tbody>
</table>

**CLAIM SPECIFIC MESSAGE(S):**

We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

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Continued on next page
6.7 EXAMPLE OF MEDICAL-SURGICAL EOB, Continued

**Message Code descriptions**

Descriptions for the Message Codes used in the claim details are provided at the end of the EOB.

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**Example EOB Image**

[Image of an EOB from ABC FAMILY HEALTH with provider number 0997664121 and provider name ABC FAMILY HEALTH from September 30, 2017. The EOB includes various codes and messages, such as MESSAGE 99: If you have questions, please call 1-866-731-9000.]

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**Payment Codes**

- 023 = PREMIER BLUE SHIELD
- 026 = CONTRACTOR ALLOWANCE
- 033 = COMMUNITY BLUE PPO
- 039 = MEDICARE ADVANTAGE

**Non-Chargeable Amount Codes**

- 25 = Differential
- 30 = Medicare Advantage

**Member Liability Codes**

- A1 = Deductible
- D1 = Copay
- H1 = Rejected Billable Non-Covered Service

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**Footer**

HIGHMARK PROVIDER MANUAL | Chapter 6.7
Billing & Payment: Payment/EOBs/Remittances

10 | Page
6.7 FACILITY PAYMENT METHODOLOGY

Overview

Highmark develops and maintains reimbursement methodologies for facility-type providers (UB-04/837I billers) that allow claims to pay at industry standards as well as taking into account the specific needs of the network participating facilities in our service areas. Reimbursement is in accordance with the payment and reimbursement terms contained in the provider's agreement.

Facility inpatient

Highmark's general reimbursement methodology for commercial inpatient claims is designed to establish, on a prospective basis, fixed rates for inpatient services. Payment for medical/surgical inpatient services will be made on a per case basis, using the DRG (diagnosis related group) patient classification system.

Highmark develops their own DRG weights. However, the Centers for Medicare & Medicaid Services (CMS) reimbursement methods are reviewed regularly to determine what the impacts are to Highmark's reimbursement methods. These updates can occur annually or quarterly depending on the provider type.

Facility Outpatient: Highmark OPPS-based payment method

Highmark has adopted the Medicare Outpatient Prospective Payment System (OPPS) that is based on the Ambulatory Payment Classification (APC) system and the use of the OPPS components in Highmark APC-based payment methods. OPPS was designed to pay acute care hospitals for most outpatient services.

The Highmark OPPS-based payment method is designed to use all of the features, values, and workings of the Medicare OPPS, with the exception of select customized features. The payment method includes the APC grouper and pricer, relative weights, applicable edits, and quarterly updates.

Since its inception, CMS has made, and continues to make, changes and refinements to APCs and the entire OPPS. These changes are made every calendar quarter, with the most significant changes occurring at the start of each calendar year.

Highmark evaluates the appropriateness of CMS’ new or revised components for potential modification. Highmark's implementation of each quarterly update is based on the time frame in which CMS releases the quarterly change notices and Highmark's receipt of such changes via the vendor software. The date of implementation will be posted in advance via the Highmark OPPS calendar on the Provider Resource Center in NaviNet.

For more details, you can find the Highmark OPPS Based Payment Method Provider Training Manual, and also the APC Pricing Component Calendar, on the Provider Resource Center in NaviNet. Select CLAIMS, PAYMENT & REIMBURSEMENT from the main menu.

Continued on next page
6.7 FACILITY PAYMENT METHODOLOGY, Continued

**SNF RUG-based payment methodology**

Highmark uses a Resource Utilization Group (RUG) based payment methodology for all participating skilled nursing facility providers for both commercial and Medicare Advantage products. RUG-based reimbursement more closely approximates the relative resource intensity associated with treating individual skilled patients. Each RUG category translates into a per diem payment that is specific to each patient’s condition.

The Highmark methodology is designed to use all of the features, values, and workings of the Medicare per diem payment methodology with only a few exceptions.
6.7 FACILITY REMITTANCE ADVICE

Introduction

The Provider Remittance Advice is provided by Highmark’s claim processing system and accounts for all claims adjudicated in the payment cycle, whether paid or denied. The Remittance Advice displays how the claim processes, including contractual adjustments, payments, and member liabilities.

Remittance types and availability

The facility Provider Remittance Advice is available in an online version via NaviNet® and is in PDF format, which can be downloaded, printed, or saved. For all Friday evening payment cycles, the Remittance Advice document is viewable on Monday morning.

Providers can also choose to receive their claim payment information via an electronic remittance advice (Version 5010 – 835). Receipt of the 835 can be set up directly through Highmark’s Electronic Data Interchange (EDI) or through contacting your electronic vendor or clearinghouse. For all Friday evening payment cycles, the 835 is available for viewing by Monday morning. The actual availability of the 835 files may also depend on your vendor.

Electronic Funds Transfer (EFT) payments associated with both the facility Remittance Advice and the Version 5010-835 are available on Wednesday.

EDI support

For information on electronic remittance advice (Version 5010-835), please visit the Highmark EDI Services website. The EDI website is accessible on the Provider Resource Center by selecting CLAIMS, PAYMENT & REIMBURSEMENT, or by clicking on the applicable link below for your service area:

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

An EDI support analyst may also be contacted by phone at 1-800-992-0246.

Parts of the Remittance Advice

The facility Provider Remittance Advice contains the following sections, in this order:

1. Recipient Payment Summary
2. Provider Payment Check Totals
3. Explanation of Provider Detail Headings
4. Credit Balance Detail
5. Detail Report

The sections of the Remittance Advice, including images, are explained on the pages that follow.

Continued on next page
6.7 FACILITY REMITTANCE ADVICE, Continued

Recipient Payment Summary

The first section of the Remittance Advice provides a summary of check and payment information for all four payment types that will be detailed on the Provider Payment Check Totals pages. The Recipient Payment Summary consists of two pages:

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Regular</th>
<th></th>
<th>Federal HMO</th>
<th></th>
<th>FEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567890</td>
<td>99xxxxxx</td>
<td>4.236,910.90</td>
<td>99xxxxxx</td>
<td>38,461.19</td>
<td></td>
</tr>
</tbody>
</table>

1. The recipient ID Number identifies the provider by NPI.
2. The check number(s) and check amount(s) for each of the following payment types—Regular, Federal HMO, and FEP—are provided here for the applicable provider number(s).
3. Total payment amounts of check(s) for each payment type on this page (Regular, Federal HMO, and FEP).
4. Total number of checks and the total payment amount associated with this remittance.
5. Provider name and billing address.

Continued on next page
Recipient Payment Summary (continued)

1. The recipient ID Number identifies the provider by NPI.
2. The check number(s) and check amount(s) for National Alliance payments are provided here for the applicable provider number(s).
3. Total payment amount of check(s) for National Alliance Accounts (no payment in this example).
4. Total number of checks and the total payment amount associated with this remittance.
5. Provider name and billing address.

Note: The information in fields labeled 1, 4, & 5 is duplicated on both pages of the Recipient Payment Summary.

Continued on next page
6.7 FACILITY REMITTANCE ADVICE, Continued

Provider Payment Check Totals

This page summarizes the claim amounts that were totaled to determine this payment. It also provides the facility’s check, no-pay check, or Electronic Funds Transfer (EFT) Notice of Deposit information. There are four PROVIDER PAYMENT CHECK TOTALS pages, in the following order:

1. **REGULAR PAYMENT** – Payment information for claims for all Highmark members and for out-of-area BlueCard claims, including both Regular and Complementary utilization.
2. **FEP PAYMENT** – Payment information for claims for members of the Blue Cross Blue Shield Federal Employees Program (FEP), with the exception of those in an HMO program.
3. **FEDERAL HMO PAYMENT** – Payment information for claims for federal employees enrolled in an FEP HMO program.
4. **NATIONAL ALLIANCE** – Payment information for claims for members with coverage under self-funded National Alliance Accounts powered by Highmark Blue Shield.

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1. Payment area will display either check or electronic funds payment information (depending on your facility’s selection).
2. Provider number and name populated here.
3. Payment amount, date, and remittance page number are displayed here.
4. Payment type (Regular, FEP, Federal HMO, or National Alliance).
5. This area indicates the total dollar amount for claims of this type included in this remit and any interest or adjustment, if applicable.
6. The dollar amount for this type of payment will be shown here and withheld amounts, if applicable.

Continued on next page
6.7 FACILITY REMITTANCE ADVICE, Continued

Explanation of Provider Detail Headings

This key to the fields on the Detail Report will follow each of the Provider Payment Check Totals pages. It provides the complete name for each field but no descriptions. (The page with this key will not have a page number.)

For more detailed descriptions of each field, please see the Remittance Advice Detail Heading Descriptions.

Continued on next page
### 6.7 FACILITY REMITTANCE ADVICE, Continued

**Credit Balance Detail**

This page displays a summary of all offsets applied against the facility check or EFT payment, as well as any offset amounts that remain outstanding (Remaining Credit Balance). The page will not appear in the Remittance Advice if there are no offsets applied.

This page will appear immediately after the applicable Provider Payment Check Totals page (e.g., if applied to the Regular Payment, which is Page 1, then the Regular Payment Credit Balance Detail would be Page 2).

<table>
<thead>
<tr>
<th>PAT CONTROL NUMBER</th>
<th>MEMBER ID</th>
<th>PATIENT NAME/First</th>
<th>CLAIM NUMBER</th>
<th>REMIT DATE</th>
<th>TOTAL CREDIT AMT</th>
<th>CREDIT APPLIED TO A previous REMITTANCE</th>
<th>ADJUSTED CREDIT APPLIED TO THIS REMITTANCE</th>
<th>REMAINING CREDIT BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12345-JP</td>
<td>1000000000</td>
<td>PUBLIC JOHN</td>
<td>0987654321</td>
<td>2020-01-01</td>
<td>123.45</td>
<td>0.00</td>
<td>123.45</td>
<td>0.00</td>
</tr>
<tr>
<td>13456-JP</td>
<td>2000000000</td>
<td>PUBLIC JOHN</td>
<td>2109876543</td>
<td>2020-02-02</td>
<td>123.45</td>
<td>0.00</td>
<td>123.45</td>
<td>0.00</td>
</tr>
</tbody>
</table>

| TOTALS             |           |                    |              |            | 246.90           | 0.00                                   | 246.90                      | 0.00                      |

1. Indicates type of payment for the credit balance detail being displayed.
2. Remit date and page number.
3. Credit balance detail area with one line of information for each offset.
4. Dollar amount totals for each column on the page.

Continued on next page
6.7 FACILITY REMITTANCE ADVICE, Continued

**Detail Report**

This report displays extensive payment information for each claim paid on this remittance advice. The report is broken down by type of utilization based on product. Within each category, the reports are divided further into Inpatient and Outpatient claims. Categories include:

- Regular Utilization Indemnity
- Complementary Utilization Indemnity
- Special Care
- Workers Comp
- Self-Insured
- Regular Utilization Network
- Complementary Utilization Network
- Security Blue
- FEP
- Major Medical
- Freedom Blue
- Community Blue
- Medicare HMO
- National Alliance

---

1. Type of utilization based on product.
2. Indicates whether claims are inpatient or outpatient.
3. Claim information detail area with up to five lines of information for each claim.
4. Column collar amount totals for the page.
6.7 ANSI CLAIM ADJUSTMENT GROUP AND REASON CODES

Overview

American National Standard Institute (ANSI) codes are used to explain the adjudication of a claim and are the CMS-approved ANSI messages. **Group codes must be entered with all reason code(s) to establish financial liability for the amount of the adjustment or to identify a post-initial-adjudication adjustment.**

ANSI Group Codes (AGC)
The table below defines the ANSI Claim Adjustment Group Codes that appear in the field represented as AGC (column 2, line 4) on the Highmark Remittance Advice Detail Report:

<table>
<thead>
<tr>
<th>GROUP CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Responsibility (PR)</td>
<td>This code is used when the amount rejected is billable to the insured or the patient. Examples would include: amounts applied to deductibles, coinsurance, copayments, subscriber penalties, and patient assumed financial responsibility for a service considered not medically necessary. The amount adjusted is the responsibility of the patient.</td>
</tr>
<tr>
<td>Contractual Obligation (CO)</td>
<td>This code is used when the amount rejected is non-billable to the insured or the patient. The amount adjusted is not the patient’s responsibility under any circumstance because of the obligation that exists between the provider and the payer, or because a regulatory requirement is in existence.</td>
</tr>
<tr>
<td>Payer Initiated (PI)</td>
<td>This code is used when the amount rejected is non-billable to the insured or the patient. In the opinion of the payer, the amount rejected is not the responsibility of the patient <strong>without a supporting contract between the provider and the payer.</strong></td>
</tr>
<tr>
<td>Other Adjustment (OA)</td>
<td>This is used when the amount rejected is non-billable to the insured or the patient. Additionally, this is used when there are miscellaneous adjustment being made to the rejected claim (for example, if the service is being processed on another claim that has not been paid). If no other category is appropriate, this one will be used.</td>
</tr>
</tbody>
</table>

Continued on next page
### 6.7 ANSI CLAIM ADJUSTMENT GROUP AND REASON CODES, Continued

<table>
<thead>
<tr>
<th>GROUP CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correction and Reversal (CR)</td>
<td>This code is used when the amount rejected is non-billable to the insured or the patient. For example, if the provider withdraws a claim, the claim will be rejected on reconciliation as a rejected claim. The claim is a reversal of a previously reported claim or claim payment.</td>
</tr>
</tbody>
</table>

ANSI Claim Adjustment Reason Codes (CARCs) appear on the remittance, designated as ARC (column 2, line 4), to communicate an adjustment. These codes explain why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code on the remittance.

Below is a list of commonly used Claim Adjustment Reason Codes:

1. Deductible Amount
2. Coinsurance Amount
3. Copayment Amount
18. Duplicate claim/service
29. The time limit for filing has expired.
35. Lifetime benefit maximums have been reached.
49. Non-covered services - Routine
78. Non-covered days/Room charge adjustment
96. Non-covered charge(s)
119. Benefit maximum has been reached for this time period.

6.7 OVERPAYMENTS AND REFUNDS

Introduction

Highmark offers streamlined, electronic processes that simplify how you notify Highmark of claim overpayment and how Highmark will notify you when we identify overpayments.

Provider identifies overpayment

If a provider identifies an overpayment:

- All Highmark-hosted NaviNet-enabled providers must use NaviNet’s Claim Investigation Inquiry to notify Highmark of an overpayment. If you are not NaviNet-enabled and an overpayment was made, call Highmark Provider Services to advise if you want the overpayment offset from a future payment.

- If Highmark agrees that an overpayment exists, it will adjust the payment so that the next Explanation of Benefits (EOB) statement and Electronic Remittance Advice (835) transaction (if used) will include details of the changes in the payment. It will also reduce the total payment for that EOB/835 by the amount of the overpayment. The EOB/835 detail, on a line-item basis, is clear and easy to post in your accounts receivable software. If you take advantage of the Electronic Remittance Advice (835) transaction, your office/facility can automatically post the refund.

- While less desirable, if you prefer to refund the amount of overpayment by sending a check, please do not use NaviNet’s Claim Investigations Inquiry or call Highmark Provider Services. Rather, send a check and a copy of the EOB with the overpaid claim circled to:

<table>
<thead>
<tr>
<th>PENNSYLVANIA</th>
<th>DELAWARE</th>
<th>WEST VIRGINIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highmark</td>
<td>Highmark Blue Cross Blue Shield Delaware</td>
<td>Highmark</td>
</tr>
<tr>
<td>Attn: Cashier</td>
<td>Attn: Treasury</td>
<td>Attn: Cashier</td>
</tr>
<tr>
<td>P.O. Box 898820</td>
<td>P.O. Box 1991</td>
<td>P.O. Box 890150</td>
</tr>
<tr>
<td>Camp Hill, PA 17089-0150</td>
<td>Wilmington, DE 19899-1991</td>
<td>Camp Hill, PA 17001-9774</td>
</tr>
</tbody>
</table>

**CHIP Provider Self Audit Protocol**

Per the Pennsylvania Children’s Health Insurance Program (CHIP) Provider Self Audit Protocol, providers are to mandatorily disclose overpayments or improper payments of CHIP funds within sixty (60) days of identification and provide written description of the reason for the overpayment or improper payment.

Why blue italics?
6.7 OVERPAYMENTS AND REFUNDS, Continued

If Highmark identifies an overpayment:

- Highmark will notify your practice of all overpayments on a separate section of the EOB and Electronic Remittance Advice (835) transaction, if used. Highmark will no longer send notification of overpayment letters to you. The overpayment details in the new section of the EOB (future offset summary) and 835 reference an overpayment that will be withheld from a future check.

- The EOB/835 provides detail as to the reason for the refund request. It serves as notice that unless appealed or paid by check, the overpayment will be deducted from an EOB/835 approximately sixty (60) days following the notification.

- If you agree with the refund request, you should take no action. Highmark will automatically deduct the overpayment from a future check. The deduction will be indicated on your EOB/835. If you do not want the overpayment withheld from a future check but prefer to write a check for the overpayment, send the check and a copy of the EOB with the overpaid claim circled to:

<table>
<thead>
<tr>
<th>PENNSYLVANIA</th>
<th>DELAWARE</th>
<th>WEST VIRGINIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highmark</td>
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<td>Wilmington, DE 19899-1991</td>
<td>Camp Hill, PA 17001-9774</td>
</tr>
</tbody>
</table>
6.7 ELECTRONIC MANUAL PAYMENTS

Policy

When a manual payment is requested for a provider and the provider is both EFT and NaviNet®-enabled, Highmark will send the provider an electronic payment instead of a paper check. **Electronic manual payments will have a unique check number that will begin with “77” (e.g., 7700000001).** An electronic remittance advice/EOB will not be issued for electronic manual payments.

How to obtain electronic manual payment information

You can use NaviNet’s Cash Management function to see payment details for an electronic manual payment. The Cash Management transaction provides a weekly payment accumulation and a summary of payments received for the current year. In addition, you may retrieve individual check details.

To access check details, select **AR Management** from the Highmark Plan Central menu, and then select **Cash Management** from the fly-out menu. Click on the applicable check number from the list on the Provider Payment and History Inquiry page. On the check’s Detail Information screen, you are able to view additional information about the payment in the **Comments** field:

![Check/EFN Number: 7700000001](image)

**Comments:** Patient John Doe Date of Service 11/01/13 Claimid 12345678900

---

**FOR MORE INFORMATION**

Highmark provides NaviNet at no cost to network participating providers. NaviNet integrates all insurer-provider transactions into one online system. For additional information about Highmark’s requirements for enrollment in NaviNet, EFT, and paperless EOBs, please see the section titled “Electronic Transaction Requirements” in **Chapter 1.3: Electronic Solutions-- EDI & NaviNet.**
6.7 PAYMENT FOR FEP MEMBERS OVER 65

Federal Employee Program (FEP) For certain Federal Employee Program (FEP) members age 65 or more who do not have Medicare, the Federal Employee Health Benefit (FEHB) law limits payments for inpatient hospital care and physician care to what Medicare would pay. Outpatient hospital care and non-physician based care are not covered by this law.

The following chart provides information about the limits:

<table>
<thead>
<tr>
<th>IF THE FEP MEMBER IS…</th>
<th>THEN, FOR INPATIENT HOSPITAL CARE…</th>
<th>AND FOR PHYSICIAN CARE…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• age 65 or over; and</td>
<td>• the law requires payment based on</td>
<td>The law requires the</td>
</tr>
<tr>
<td>• does not have Medicare</td>
<td>an amount set by Medicare’s rules</td>
<td>member’s applicable</td>
</tr>
<tr>
<td>Part A, Part B, or both; and</td>
<td>for what Medicare would pay, not</td>
<td>coinsurance or copayment</td>
</tr>
<tr>
<td>• has the FEP Plan as an</td>
<td>the actual charge; the member is</td>
<td>be based on:</td>
</tr>
<tr>
<td>annuitant or as a former</td>
<td>responsible for applicable cost-sharing amounts</td>
<td>• the Medicare approved</td>
</tr>
<tr>
<td>spouse, or as a family</td>
<td>(i.e., coinsurance); the member is</td>
<td>amount, or</td>
</tr>
<tr>
<td>member of an annuitant or</td>
<td>not responsible for any charges greater than the Medicare</td>
<td>• the actual charge if it is</td>
</tr>
<tr>
<td>former spouse; and</td>
<td>approved amount; the law prohibits a hospital from</td>
<td>lower than the Medicare</td>
</tr>
<tr>
<td>• is not employed in a</td>
<td>collecting more than the Medicare approved amount.</td>
<td>approved amount.</td>
</tr>
<tr>
<td>position that gives FEHB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>coverage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following table explains member responsibility under each plan option:

<table>
<thead>
<tr>
<th>IF THE PHYSICIAN…</th>
<th>THEN THE FEP MEMBER IS RESPONSIBLE FOR…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network.</td>
<td>Standard Option: Deductibles, coinsurance, and copayments</td>
</tr>
<tr>
<td></td>
<td>Basic Option: Copayments and coinsurance</td>
</tr>
<tr>
<td>Participates with Medicare or accepts Medicare assignment and is not in the Preferred network</td>
<td>Standard Option: Deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount</td>
</tr>
<tr>
<td></td>
<td>Basic Option: All charges</td>
</tr>
<tr>
<td>Does not participate with Medicare and is in our Preferred network</td>
<td>Standard Option: Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount</td>
</tr>
<tr>
<td></td>
<td>Basic Option: Copayments and coinsurance, and any balance up to 115% of the Medicare approved amount</td>
</tr>
<tr>
<td>Does not participate with Medicare and is not in our Preferred network</td>
<td>Standard Option: Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount</td>
</tr>
<tr>
<td></td>
<td>Basic Option: All charges</td>
</tr>
</tbody>
</table>
6.7 PAYMENT FOR THE PENNSYLVANIA CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

PROMISe™ ID enrollment required for CHIP payment

Effective January 1, 2018, the Pennsylvania Department of Human Services (DHS) implemented the Affordable Care Act (ACA) Provider Enrollment and Screening provisions that require all providers who render, order, refer, or prescribe items or services to Children’s Health Insurance Program (CHIP) enrollees to have a valid PROMISe™ ID. A valid PROMISe ID is required to receive payment for CHIP enrollee claims.

For more information about PROMISe ID enrollment, please see the manual’s Chapter 3.1: Network Participation Overview.

Reimbursement

Participating providers accept Highmark’s reimbursement for services as payment in full without balance billing the enrollees. There is no additional discount applied to provider reimbursement rates due to income level (providers receive the full Highmark reimbursement rate).

For CHIP HMO plans in the Western and Northeastern Regions, if covered services are not available from a network provider, preauthorization must be obtained to receive services from a provider outside the network.

For CHIP PPO Plus in the Central Region, non-network providers may bill the enrollee for the difference between the indemnity fee for a given procedure and the actual charge made for that procedure.

CHIP Provider Self Audit Protocol

Per the Pennsylvania Children’s Health Insurance Program (CHIP) Provider Self Audit Protocol, providers are to mandatorily disclose overpayments or improper payments of CHIP funds within sixty (60) days of identification and provide written description of the reason for the overpayment or improper payment.

For more information on reporting overpayments to Highmark, please see the Overpayments and Refunds section of this unit.

FQHC/RHC payment and claim submission

Section 503 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires payment for services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be at least equivalent to Medicaid Prospective Payment System (PPS) rates for all CHIP encounters. The PPS rates are all-inclusive rates for encounter services provided, except for vaccine services.

Continued on next page
6.7 PAYMENT FOR THE PENNSYLVANIA CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP), Continued

FQHC/RHC payment and claim submission (continued)

All FQHCs and RHCs must bill for services using the T1015 procedure code. The T1015 code is the required code to be able to pay the all-inclusive PPS rate and is defined as “clinic visit/encounter, all-inclusive.”

When the FQHC is using the 1500 Claim Form, they must list T1015 in the first section of Item #24d. All pertinent services furnished during the encounter should be listed in the claim. FQHC PPS specific payment codes are listed on the Centers for Medicare & Medicaid Services (CMS) website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

General Guidelines for CHIP FQHC/RHC Claim Submissions:
1. Providers should include the T1015 HCPCs code indicating an encounter/service meeting the guidelines for CHIP has occurred.
2. Providers should bill T1015 HCPCs with a zero charge.
3. T1015 code must be billed on the same claim as the office visit and not separately.
4. Reimbursement at the PPS encounter rate may be split across lines on the claim. Base Pricing will prorate the claim allowance on eligible lines in order to apply the entire encounter/claim allowance to the claim.
5. All other procedures performed during the encounter on the claim (e.g. office visit, screening, behavioral assessment, etc.) must be billed with a charge amount and the procedure CPT code (as they would normally submit). Zero charge lines reported for CHIP enrollees will reject.
6. All vaccines should be billed with charge amounts and associated CPT code and do not need to be billed with the T1015 code.
7. Vaccine administration charges will be reimbursed as part of the encounter rate for that visit.
8. CHIP does not reimburse more than charge. Each claim is capped at charge before any enrollee liability and approved amounts are calculated.
9. CHIP enrollees may be liable for copays based on services.

Questions on FQHC PPS can be emailed to: FQHC-PPS@cms.hhs.gov

To learn more about Pennsylvania’s CHIP program, please see the manual’s Chapter 2.3: Other Government Programs.
6.7 NON-NETWORK PAYMENT GUIDELINES

**Overview**
Non-network providers do not sign an agreement with Highmark. Therefore, they have no contractual obligation to accept Highmark’s allowance as payment-in-full. However, non-network providers are required to accurately report services performed and fees charged.

**Payment policy**
Highmark payment for covered service performed by non-network providers goes directly to the member who is responsible for reimbursing the non-network provider. Non-network providers do not receive Explanation of Benefits (EOB) statements.