Special Bulletin

For professional and facility providers **July 5, 2023**

Use of Self-Service Tools Now Required For Routine Claims Inquiries

Call volumes at Highmark have remained higher than normal resulting in extended wait times, even with increased support within our call centers. We know that you have better things to do than wait on hold for information, and we want to help you get back to caring for your patients and managing your office.

To help reduce wait times and allow you to speak more quickly to a live provider representative when you have a unique or urgent need, **Highmark will begin requiring providers to use our self-service tools for questions related to claims status or claims investigation on July 26, 2023.**

The Provider Call Center will no longer be able to provide information regarding claims status and claims inquiry. Instead, our representatives will direct you to our self-service tools that are available by logging into NaviNet® or by using our Interactive Voice Response (IVR) system.

Self-Service Tools

Highmark offers several provider self-service tools available through NaviNet, Highmark's Provider Resource Center, and our Interactive Voice Response (IVR) to quickly manage your routine inquiries.

These tools can help providers reduce administrative costs, improve office workflows, and assist in the collection of claim payments. Please encourage your third-party vendors (clearinghouse, billing companies, etc.) to also use these self-service tools.

NaviNet

Electronically submit claims and other payer/provider transactions to Highmark. If you have not signed up for NaviNet, learn how to do so here.

Quick Start Guide to using the most common functions.

Provider Resource Center

A communication/education tool for Highmark's provider network to stay updated on the latest policies, procedures, and news.

Links to regional websites.

Telephone (IVR)

An automated, Interactive Voice Response (IVR) telephone system available 24 hours a day, 7 days a week, and allows providers to inquire about authorization and claim status.

These tools support a variety of clinical, financial, and administrative self-service capabilities. Below are details on how to use the self-service options for some claims transactions. There are ***many*** more services that our tools support, including eligibility and benefits, authorization submission, etc. Our self-service tools are the preferred way to get quick answers for many needs.

- Claim Status
- Claim Investigation
- Unresolved Billing Disputes
- Top Billing Errors to Avoid

Third Parties

Please encourage your third-party vendors (billing companies, credentialing agencies, etc.) to also use these self-service tools. They can enroll in NaviNet by visiting navinet.navimedix.com and clicking "Register for a new account." (Do not add users from third parties to your facility/practice's NaviNet account; they must create their own NaviNet account.)

Claims Status

- **NaviNet –** *Quick Start Guide*
    - The Claim Status Inquiry function allows you to 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.
- **Interactive Voice Response (IVR)**
    - Call the Provider Service Center for your region.
    - Enter the provider's NPI number.
    - Enter the member's Highmark ID or social security number.
    - Enter or say the member's birthdate.
    - Say "Claims."
    - Enter or say the date of service.
    - The system will provide a summary of the claim (Service date(s), charges, process date, member responsibility, who claim is paid)
    - If you ask for "More Details," you will also hear details, such as: "claim number," number of charges on claim, provider responsibilities, paid amount.

Claim Investigation

- **NaviNet –** *Quick Start Guide*
    - **First Inquiry:** Locate the claim in Claims Status Inquiry, and then click Claim Investigation to send your inquiry to Provider Service.

- **Second Inquiry:** Any provider who treats a Highmark member has the right to dispute claims payment decisions made by Highmark. If you do not agree with the response to your claim investigation or need additional information, select Claim Investigation from within your inquiry to send an additional (second) inquiry to Provider Service.
- **Third+ Inquiry:** You may submit additional Claim Investigations if needed.

Unresolved Billing Disputes

Any claims review dispute involving claims submitted by a health service provider that remains unresolved may be submitted for an appeal. Please see *Highmark's Provider Manual* on the Provider Resource Center, Chapter 6 Unit 1.

Top Billing Errors to Avoid

Below are ten common errors that may cause a claim to process incorrectly.

Reporting Error	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.

Provider Resource Center Websites

The Provider Resource Center (PRC) is the main communication/education tool for Highmark's provider network to stay updated on the latest policies, procedures, and news. Visit the website for the region in which you are contracted.

Highmark Blue Shield	hbs.highmarkprc.com
Highmark Blue Cross Blue Shield	hbcbs.highmarkprc.com
Highmark Blue Cross Blue Shield Delaware	hdebcbs.highmarkprc.com
Highmark Blue Cross Blue Shield West Virginia	hwvbcbs.highmarkprc.com