CLAIMS & REIMBURSEMENT

Highmark pays claims for services performed by licensed, eligible health care providers. Eligible providers may sign an agreement to participate in one or more of Highmark's provider networks. Providers who choose not to participate in Highmark's networks must register with Highmark prior to submitting claims for covered services.

As a participant in any of Highmark's networks, providers agree to provide services to Highmark members according to the terms of their agreement, the regulations that outline their obligations to Highmark members, and any relevant administrative requirements. Although they do not sign an agreement with Highmark, non-network providers are required to accurately report services performed and fees charged.

ELECTRONIC CLAIM SUBMISSION

Electronic transactions and online communications have become integral to health care. Highmark places a high priority on electronic exchange of information and electronic claims filing. This process is more efficient and cost-effective than conventional means – benefiting health care facilities, professionals, and members. Electronic claims are convenient, confidential, and operational around the clock and increases staff productivity by speeding claim preparation and delivery.

ELECTRONIC DATA INTERCHANGE (EDI) SERVICES

Highmark's electronic commerce division, Electronic Data Interchange (EDI) Services, provides a host of services that make filing claims and accessing information faster and easier. These include:

- A claims clearinghouse where you can electronically submit claims and inquiries for Highmark and other insurers
- Convenient technical support through a toll-free hotline
- Information on getting started in electronic claims filing

HIGHMARK'S NAVINET PROVIDER PORTAL

Highmark makes NaviNet® available to all participating providers at no cost. NaviNet is an internet- based application for providers to streamline data exchanges between their offices and health insurance companies. Through Highmark's NaviNet provider portal, providers are able to submit claims through HIPAA-compliant claim submission transactions.

NaviNet claim submission transactions let you submit 837P Professional claims and 837I Institutional claims fast and easy in real-time. NaviNet's real-time single claim submission lets you know the status of a claim at the time of entry and claim errors are corrected online. When submitted on the date the services were rendered, these capabilities allow providers to accurately identify and collect member responsibility before the patient leaves the office.

NaviNet 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. You can also launch a claims investigation and have the claim researched without going back to Plan Central or making a call to Highmark.

HIGHMARK'S 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.

REIMBURSEMENT AND EOBS/REMITTANCES

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. 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.

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.

Network participating professional providers receive an Explanation of Benefits (EOB) statement listing all claims processed each week. This EOB lists each patient's claim separately. All Highmark EOBs are available electronically on NaviNet.

- Delaware, Pennsylvania, and West Virginia providers can also view EOBs on PNC's ECHO Health platform. You'll need to visit ECHO's provider platform to manage/change payment information.

Highmark develops and maintains reimbursement methodologies for facility-type providers (UB/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.

The facility 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.

- For Delaware, Pennsylvania and West Virginia providers, the Remittance Advice is available in an online version via NaviNet®. To download or print your Electronic Remittance Advice (ERA), you'll need to visit ECHO Health's platform.
- For New York providers, you will be able to view, download or print your ERAs through NaviNet.

All Highmark network participating providers are required to enroll in Electronic Funds Transfer (EFT) and paperless Explanation of Benefits (EOB) statements.

- EFT is a secure process that directs Highmark claim payments to the provider's checking or savings account as directed by your office. Payments are typically in the designated bank account by Wednesday of each week.
- Paperless EOB statements reduce the amount of paper flowing into the provider's office. EOBs are available for viewing on Monday morning via NaviNet - which is two days earlier than receiving them by mail.
    - For Delaware, Pennsylvania, and West Virginia providers, they are also available for viewing withing PNC Healthcare's ECHO Health platform.

***IMPORTANT**: Providers in the state of New York may still opt-in to paper Explanation of Benefits (EOBs).*

WHERE TO FIND THIS INFORMATION ON THE PROVIDER RESOURCE CENTER

CLAIMS, PAYMENT & REIMBURSEMENT: This option in the left navigation menu provides access to a wealth of information related to claims and reimbursement including, but not limited to:

- Highmark's Electronic Data Interchange (EDI) website
    - Delaware, Pennsylvania, West Virginia only
- Medical Policy
- Procedures/Services Requiring Authorization
- Reimbursement Policy

FEE SCHEDULES: Highmark fee schedules are available **ONLY** on the Provider Resource Center in NaviNet under **CLAIMS, PAYMENT & REIMBURSEMENT**. You can also search for the allowance for a specific procedure code in NaviNet -- select **Allowance** under **Workflows for this Plan**, and then click on **Allowance Inquiry** on the fly-out menu. Look for notifications on the Provider Resource Center and on NaviNet Plan Central for updates to fee schedules. The updates are most often communicated via Special eBulletins. You can access current and past Special eBulletins on the Provider Resource Center. Select **NEWSLETTERS/NOTICES** from the main menu, and then **Special Bulletins & Mailings**.

EFT AND PAPERLESS EOBS (NY Only): The **EFT Attestation and Registration Guide** provides instruction for enrolling in EFT and paperless EOBs through NaviNet. Delaware, Pennsylvania, and West Virginia providers should register for EFT through ECHO Health.

- If you need assistance signing up for the ECHO Provider Portal, a user guide is available. You can also watch this video which walks you through use of the ECHO Provider Portal.

HIGHMARK PROVIDER MANUAL: The *Highmark Provider Manual's* **Chapter 6** is dedicated to billing and payment. The information below is available in the units of Chapter 6:

- Chapter 6.1: General Claim Submission Guidelines
- Chapter 6.2: Electronic Claim Submission
- Chapter 6.3: Facility (UB-04/837I) Billing
- Chapter 6.4: Professional (1500/837P) Reporting Tips
- Chapter 6.5: 1500 Claim Form Guidelines
- Chapter 6.6: Coordination of Benefits
- Chapter 6.7: Payment/EOBs/Remittances
- Chapter 6.8: Payment Review

Additional units of the *Highmark Provider Manual* that may be helpful include:

- Chapter 1.3: Electronic Solutions – EDI & NaviNet
- Chapter 3.1: Network Participation Overview
- Chapter 5.7: Value-Based Reimbursement Programs

The *Highmark Provider Manual* can be accessed from **MANUALS** on the **Quicklinks Bar** at the top of the Provider Resource Center or from **EDUCATION/MANUALS** in the main menu on the left.