Special Bulletin

For professional and facility providers **April 29, 2024**

Use of Self-Service Tools Now Required For Claim Status & Claim Investigation

Throughout the past few years, Highmark has made significant investments in our self-service tools to reduce administrative burden, improve office workflows, and simplify complex transactions.

As a result of this evolution, **Highmark will require providers in our New York service areas to use our self-service tools for questions related to claim status or claim investigation beginning August 1, 2024.**

The Highmark Provider Call Center, including FEP and BlueCard, will no longer be able to give information regarding claims status and claims investigation. Instead, our representatives will direct providers to our self-service tools that are available by logging into Availity Essentials® or by using our Interactive Voice Response (IVR) system.

Highmark rolled out the same requirement in Delaware, Pennsylvania, and West Virginia last year.

Self-Service Tools

Highmark offers several provider self-service tools available through Availity Essentials, Highmark's Provider Resource Center (PRC), 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.

Availity Essentials	Provider Resource Center	Telephone (IVR)
Electronically submit claims and other payer/provider transactions to Highmark. Log into Availity Essentials then click on Help & Training for more information. If you have not signed up for Availity Essentials, learn how to do so here.	A communication/education tool for Highmark's provider network to stay updated on the latest policies, procedures, and news. Link to New York PRC sites.	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

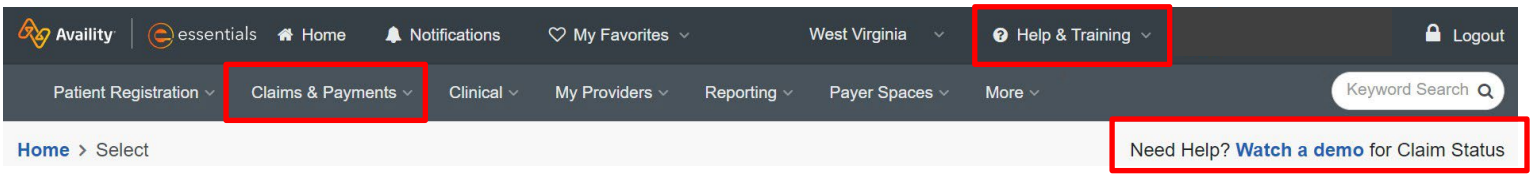
Third Parties

Please encourage your third-party vendors (billing companies, credentialing agencies, etc.) to also use these self-service tools.

- Enroll in Availity Essentials by visiting the Register and Get Started with Availity Essentials webpage.
- Do not add users from third parties to your facility/practice's Availity Essentials account; they must create their own Availity Essentials account.

Claims Status

- **Availity Essentials**
    - You can access the Claim Status function under Claims & Payments in the Availity main website menu to search for claims or view a claim status.



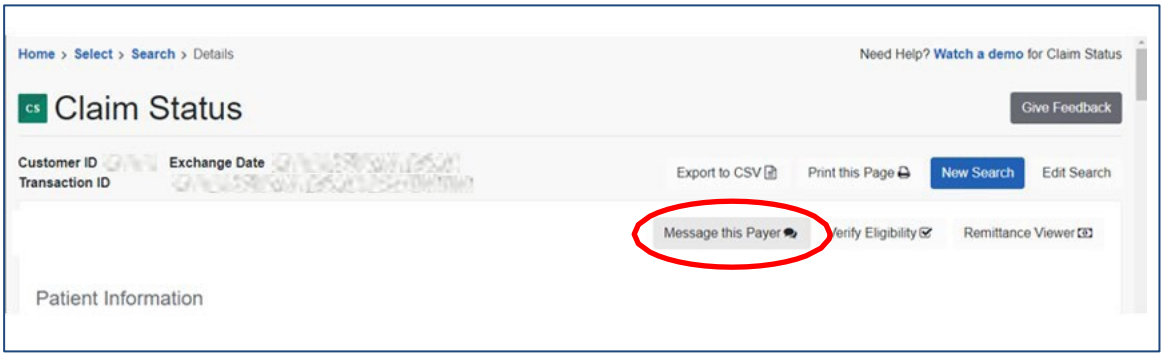
    - A demo video is available to assist you in the process. You can find the video in the top right-hand corner of the screen.
    - Additional training information can be found under Help & Training.

- **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.

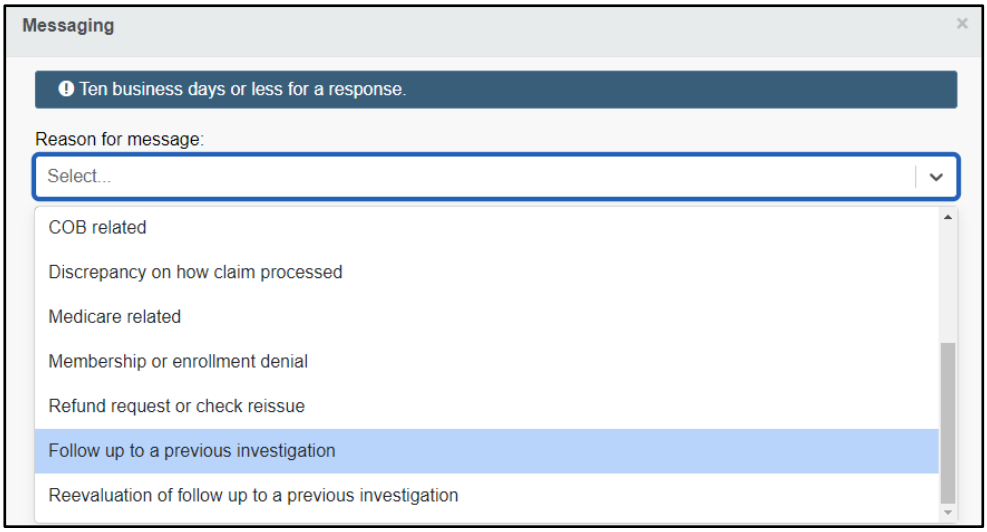
- The system will provide a summary of the claim (service date(s), charges, process date, member responsibility, who claim paid)
- If you ask for “More Details,” you will also hear details, such as: “claim number,” number of charges on claim, provider responsibilities, paid amount.

Claim Investigation

- **Availity Essentials**
  - **First Inquiry:** Locate the claim in **Claim Status**, and then click **Message This Payer** 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, locate the claim in **Claim Status**, **select Message This Payer**, and then select the option “**Follow up to a Previous Investigation**” to send an additional (second) inquiry to Provider Service.



  - **Third+ Inquiry:** You may submit additional Claim Investigations if needed by following the above instructions and choosing “**Reevaluation of a follow up to a previous investigation**" from the drop down.

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 does 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 (NENY)	hnenybs.highmarkprc.com
Highmark Blue Cross Blue Shield (WNY)	hwnybcbs.highmarkprc.com