Highmark Western and Northeastern New York

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 Implementation Guides, version 005010

January 2026

Preface

This Companion Guide to the v5010 ASC X12 Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Highmark Western and Northeastern New York. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
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1. Introduction

1.1 Scope

The Provider EDI Companion Guide addresses how Providers, or their business associates, conduct Professional Claim, Institutional Claim, Claim Acknowledgment, Claim Payment Advice, Claim Status, Eligibility, and Services Review HIPAA standard electronic transactions with Highmark Western and Northeastern New York unless specifically notated otherwise. This guide also applies to the above referenced transactions that are being transmitted to Highmark by a clearinghouse.

An Electronic Data Interchange (EDI) Trading Partner is defined as any Highmark (Provider, Billing Service, Software Vendor, Employer Group, Financial Institution, etc.) that transmits to, or receives electronic data from Highmark.

Highmark's EDI transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide. Highmark's EDI Operations supports transactions for multiple payers; each transaction chapter lists the supported payers for that transaction.

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with Highmark. This information is organized in the sections listed below.

- Getting Started: This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section**.**
- Testing with the Payer: This section includes detailed transaction testing information as well as other relevant information needed to complete transaction testing with Highmark.
- Connectivity with the Payer/Communications: This section includes information on Highmark's transmission procedures as well as communication and security protocols.

- Contact Information: This section includes telephone and email addresses for Highmark's EDI support.
- Control Segments/Envelopes: This section contains information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to Highmark.
- Payer Specific Business Rules: This section contains information describing Highmark's business rules.
- Acknowledgments and Reports: This section contains information on all transaction acknowledgments sent by Highmark. These include the TA1, Health Care Claim Acknowledgment (277CA) and the Implementation Acknowledgment for Health Care Insurance (999).
- Trading Partner Agreements: This section contains general information about and links to Highmark's trading partner agreements
- Transaction Specific Information: This section describes how ASC X12 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Highmark has something additional, over and above, the information in the IGs.

1.3 References

Trading Partners must use the ASC X12 National Implementation Guides adopted under the HIPAA Administrative Simplification Electronic Transaction rule and Highmark Western and Northeastern New York's EDI Companion guidelines for development of the EDI transactions. These documents may be accessed through Highmark Western and Northeastern New York's EDI Trading Partner Business Center:

https://edi.highmark.com/edi-ny

Trading Partners must use the most current national standard code lists applicable to the EDI transactions. The code lists may be accessed at the Washington Publishing Company website:

http://www.wpc-edi.com

The applicable code lists and their respective X12 transactions are as follows:

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221A1 Health Care Claim Payment/Advice (835))

- Claim Status Category Codes and Claim Status Codes (ASC X12/005010X212 Health Care Claim Status Request and Response (276/277) and 005010X214 Health Care Claim Acknowledgment (277CA))
- Provider Taxonomy Codes (ASC X12/005010X222A1 Health Care Claim: Professional (837P) and ASC X12/005010X223A2 Health Care Claim: Institutional (837I))
- Health Care Services Decision Reason Codes (ASC X12/005010X217 (278))

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working With Highmark

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day seven days a week, except during scheduled system maintenance periods.

Audit Procedures

The Trading Partner ensures that input documents and medical records are available for every automated claim for audit purposes. Highmark may require access to the records at any time.

The Trading Partner's automated claim input documents must be kept on file for a period of seven years after date of service for auditing purposes. Microfilm/microfiche copies of Trading Partner documents are acceptable. The Trading Partner, not his billing agent, is held accountable for accurate records.

The audit consists of verifying a sample of automated claim input against medical records. Retention of records may also be checked. Compliance to reporting requirements is sample checked to ensure proper coding technique is employed. Signature on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark may request, and the Trading Partner is obligated to provide, access to the records at any time.

Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, "string", Highmark can accept characters from the basic and extended character sets with the following exceptions:

Character	Name	Hex value
!	Exclamation point	(21)
>	Greater than	(3E)
^	Caret	(5E)
|	Pipe	(7C)
~	Tilde	(7E)
*	Asterisk	(2A)
{	Left Curly Bracket	(7B)

These seven characters are used by Highmark for delimiters on outgoing transactions and control characters for internal processing and therefore would cause problems if encountered in the transaction data.

As described in the X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. In the actual data stream trailing spaces should be suppressed. The representation for this data element type is AN.

Confidentiality

Highmark and its Trading Partners will comply with the privacy standards for all EDI transactions as outlined in the Highmark EDI Trading Partner Agreement.

Authorized Release of Information

When contacting EDI Operations concerning any EDI transactions, you will be asked to confirm your Trading Partner information.

2.2 Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from another entity.

While Highmark EDI Operations will accept HIPAA compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure be established in order to secure access to data. As a result, Highmark has a process in place to establish an Electronic Trading Partner relationship. That process has two aspects:

- A Trading Partner Agreement must be submitted which establishes the legal relationship and requirements. This is separate from a participating provider agreement.

- Once the agreement is received, the Trading Partner will be sent a logon ID and password combination for use when accessing Highmark's EDI system for submission or retrieval of transactions. This ID is also used within EDI Interchanges as the ID of the Trading Partner. Maintenance of the ID and password by the Trading Partner is detailed in the security section of this document.

Authorization Process

New Trading Partners wishing to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application process includes review and acceptance of the appropriate EDI Trading Partner Agreement. Submission of the EDI Transaction Application indicates compliance with specifications set forth by Highmark for the submission of EDI transactions. This form must be completed by an authorized representative of the organization.

Highmark may terminate this Agreement, without notice, if participant's account is inactive for a period of six (6) consecutive months.

Complete and accurate reporting of information will insure that your authorization forms are processed in a timely manner. If you need assistance in completing the EDI Transaction Application contact your company's technical support area, your software vendor or EDI Operations.

Upon completion of the authorization process, a Logon ID and Password will be assigned to the Trading Partner. EDI Operations will authorize the Trading Partner to submit production EDI transactions.

Where to Get Enrollment Forms to Request a Trading Partner ID

To receive a Trading Partner ID, you must complete an online EDI Transaction Application and agree to the terms of Highmark's EDI Trading Partner Agreement. The EDI Transaction Applications and all other EDI request forms are available through the Trading Partner Business Center on our Internet website. You may access the online Application from the page accessed by the link below.

https://edi.highmark.com/edi-ny

Receiving ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)

If you are not currently receiving Health Care Claim Payment/Advice (835) remittance transactions generated from the payment cycle in a batch process and wish to, you will need to request ERA (835) by completing an EDI Application to Update Transactions form located at the following link:

https://edi.highmark.com/edi-ny

Adding a New Provider to an Existing Trading Partner

Trading Partners currently using electronic claim submission who wish to add a new provider to their Trading Partner Number should complete a Provider Changes (Add Provider) Application located at the following link:

https://edi.highmark.com/edi-ny

Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should complete a Provider Changes (Delete Provider) Application located at the following link:

https://edi.highmark.com/edi-ny

Reporting Changes in Status

Trading Partners changing any other Trading Partner information must inform EDI Operations by completing the appropriate Trading Partner update form and including all information that is to be updated.

https://edi.highmark.com/edi-ny

Out of State Providers

Due to an operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association, Highmark Western and Northeastern New York cannot accept electronic transactions from out of state nonparticipating/out-of-network providers for Highmark Western and Northeastern New York members. Out of state nonparticipating/out-of-network providers need to enroll with their local plan for electronic claims and inquiry transactions and should submit all Blue Cross Blue Shield electronic transactions to their local Blue Cross Blue Shield Plan. The transactions will be sent on to the Plan that holds the member's enrollment, for processing through the BlueCard or BlueExchange programs.

Core operating hours for BlueExchange inquiry transactions are Monday through Saturday, 12 am to 11:59 pm. (CENTRAL TIME).

2.3 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

Testing Policy

Highmark does not currently require the testing or certification of any electronic claim or inquiry transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors ensure their software complies with all current transaction requirements.

Highmark Transactional Testing

Claims Transactions
Highmark does not allow Trading Partners to send test claim or inquiry transaction files to our production environment. A TA1 will be generated for any transaction file that has “test” indicated in the ISA15 element.

3. Testing with the Payer

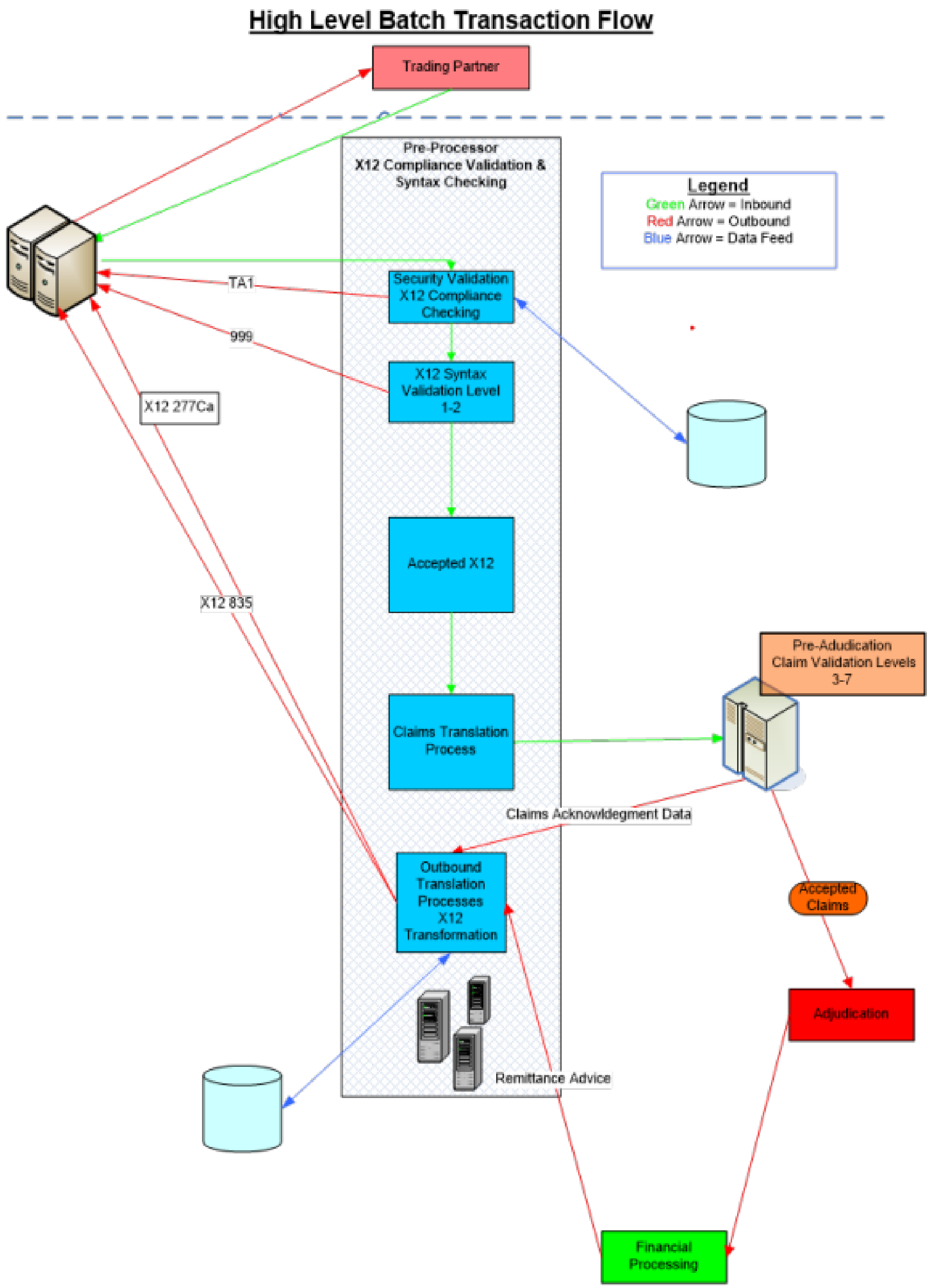
Highmark does not currently require or provide for the testing of any electronic claim or inquiry transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors test their software for HIPAA compliance on behalf of all of their clients. Any questions about the requirements contained within this Guide may be directed to EDI Operations at 1-800-992-0246 Monday through Friday 8:00am to 4:30pm, EST.

4. Connectivity with the Payer / Communications

Highmark offers its Trading Partners one type of communication method for transferring data electronically.

- File Transfer Protocol (FTP) through a secure Internet connection. Highmark’s Secure File Transfer Protocol (SFTP) platform is available for transactions in batch mode.

4.1 Process flows



4.2 Transmission Administrative Procedures

Not supported at this time.

4.3 Re-transmission procedures

Highmark does not have specific re-transmission procedures. Submitters can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Internet

Highmark offers one method to utilize the Internet for conducting electronic business with Highmark. That is secured File Transfer Protocol (FTP) through Highmark's Secure File Transfer Protocol (SFTP) platform. Highmark's Secure File Transfer Protocol (SFTP) platform is available for Trading Partners who submit or receive any HIPAA-compliant EDI transactions in batch mode.

Internet File Transfer Protocol (FTP) through Highmark's Secure File Transfer Protocol (SFTP) platform

The Highmark Secure FTP platform provides an FTP service over an encrypted data session providing "on-the-wire" privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple FTP process in an encrypted and private manner.

Any state of the art browser can be used to access the Highmark Secure FTP platform. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser.
2. Connect to the FTP servers at: https://mft.hmhs.com
3. The server will prompt for an ID and Password. Use the ID/ Password that Highmark has provided you for accessing this service. Enter the ID, tab to password field and enter the password, then hit enter or click on OK.
4. The server will then place you in your individual file space on the FTP server. No one else can see your space and you cannot

access the space of others. You will not be able to change out of your space.

5. You will need to change into the directory for the type of file you are putting or getting from the server.

6. By default, the file transfer mode will be binary, and this mode is acceptable for all data types. However, you may change between ASCII and Binary file transfer modes by clicking the “Set ASCII”/ ”Set Binary” toggle button.

7. Send Highmark a file. The following is an example of the submission of an electronic claim transaction file:

a. Click on the “hipaa-in” folder to change into that directory.

b. Click on the browse button to select a file from your system to send to Highmark. This will pop open a file finder box listing the files available on your system.

c. Select the file you wish to send to Highmark and Click on OK.

d. This will return you to the browser with the file name you selected in the filename window. Now click on the “Upload File” button to transfer the file to Highmark. Once completed, the file will appear in your file list.

8. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment For Health Care Insurance (999) file:

a. Click on the “hipaa-out” directory.

b. Your browser will list all the files available to you.

c. Click on the “ack” directory.

d. Click on the file you wish to download. Your browser will download the file. If your browser displays the file instead of downloading, click the browser back button and click on the tools next to the file you wish to receive. Select application/ octet-stream. Your system may then prompt you for a “Save As” file location window. Make the selection appropriate for your system and click on Save to download the file.

4.5 Passwords

Highmark EDI Operations personnel will assign Logon IDs and Passwords to Trading Partners. EDI Transactions submitted by unauthorized Trading Partners will not be accepted by our Highmark EDI Operations system.

Trading Partners should protect password privacy by limiting knowledge of the password to key personnel. Passwords should be changed regularly; upon initial usage and then periodically throughout the year. Also, the password should be changed if there are personnel changes in the Trading Partner office, or at any time the Trading Partner deems necessary.

Password requirements include:

- Password must be 8 characters in length.
- Password must contain a combination of both numeric and alpha characters.
- Password cannot contain the Logon ID.
- Password must be changed periodically.

5. Contact information

5.1 EDI Customer Service

Contact information for EDI Operations:

TELEPHONE NUMBER: 1-800-992-0246

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 4:30 p.m. ET, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for EDI Operations:

TELEPHONE NUMBER: 1-800-992-0246

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 4:30 p.m. ET, Monday through Friday.

5.3 Provider Service

Highmark Blue Cross Blue Shield (WNY) and Highmark Blue Shield (NENY):1-800-950-0051

Medicare Advantage: 1-800-950-0051

Hours of Availability: 8 a.m. to 5 p.m. ET, Monday through Friday

5.4 Applicable websites / e-mail

EDI specifications, including this companion guide, can be accessed online at:

https://edi.highmark.com/edi-ny

6. Control Segments / Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the national implementation guides. Highmark's expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each transaction chapter of the Transaction Information Companion Guide.

Note – Highmark only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.

6.1 ISA-IEA

Delimiters

As detailed in the national implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Highmark (inbound transmissions), the following list contains all characters that can be accepted as a delimiter. Note that LineFeed, hex value “0A”, is not an acceptable delimiter.

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1 E
!	21
“	22
%	25
&	26
‘	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B

Description	Hex value
]	5D
^*	5E
{	7B
}	7D
~	7E

* “^” may be used as a Data Element Separator, but will not be accepted as Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark will use the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, “!”, cannot be used in text data (type AN, Sting data element) within the transaction; reference section 2.1 of this document titled Valid Characters in Text Data.

Delimiter Type	Character Used	Hex value
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	{	(7B)

Data Detail and Explanation of Incoming ISA to Highmark

Segment: ISA Interchange Control Header (Incoming)

Note: This fixed record length segment must be used in accordance with the guidelines in Appendix B of the national transaction implementation guides, with the clarifications listed below.

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark can only support code 00 – No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark can only support code 00 – No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value "ZZ" Mutually Defined to designate a payer-defined ID.
	ISA06	Interchange Sender ID		Use the Highmark assigned security Login ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33	Use qualifier code value "33". Highmark only supports the NAIC code to identify the receiver.
	ISA08	Interchange Receiver ID	55204	Highmark Western and Northeastern New York
	ISA1 3	Interchange Control Number		For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.
	ISA 14	Acknowledgment Requested	1	Highmark always returns a TA1 segment when the incoming interchange is rejected due to errors at

Loop ID	Reference	Name	Codes	Notes/Comments
				the interchange or functional group envelope.
	ISA15	Usage Indicator		Highmark uses the value in this element to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from Highmark

Segment: ISA Interchange Control Header (Outgoing)

Note: Listed below are clarifications of Highmark's use of the ISA segment for outgoing interchanges.

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark will send code 00 – No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark will send code 00 – No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	33	Highmark will send qualifier code value "33" to designate that the NAIC code is used to identify the sender.
	ISA06	Interchange Sender ID	55204	Highmark Western and Northeastern New York
	ISA07	Interchange ID Qualifier	ZZ	Highmark will send qualifier code value "ZZ" Mutually Defined, to designate that a Highmark-assigned proprietary

Loop ID	Reference	Name	Codes	Notes/Comments
				ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The Highmark-assigned ID will be the trading partner's security login ID. This ID will be left-justified, and space filled.
	ISA 14	Acknowledgment Requested		Highmark always uses a 0 (No Interchange Acknowledgement Requested).
	ISA15	Usage Indicator		Highmark provides T or P to identify the test orproduction nature of all transactions within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS-GE can be found with the related transaction in sections 7 (Payer Specific Rules and Limitations) and 10 (Instruction Tables) of the Transaction Information Companion Guide.

6.3 ST-SE

Highmark has no requirements outside the national transaction implementation guides.

7. Payer Specific Business Rules and Limitations

7.1 005010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 Implementation Guide, as modified by the June 2010 Type 1 Errata Document, is the primary source for definitions, data usage, and requirements.

This section and the corresponding transaction data detail make up the companion guide for submitting Health Care Claim: Professional (837P) claims.

Patient with Coverage from another Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept Health Care Claim: Professional (837P) claims when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha/numeric prefix. Highmark Western and Northeastern New York's NAIC 55204 must be listed in the Application Receiver GS03 and in the loop 2010BB NM109 Payer ID. Highmark will use the Member ID alpha/numeric prefix to identify the need to coordinate processing with another Plan. If the alpha/numeric prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local Highmark Western and Northeastern New York member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark's system, the claim would be denied for no coverage and any payment due the provider would be delayed until the claim is corrected and resubmitted.

This operating arrangement allows Highmark Western and Northeastern New York to be an electronic interface for its local providers to out-of-state Plans that are licensees of the Blue Cross Blue Shield Association. Any payment to the provider will be made by Highmark.

Dental Services

Dental services that are reported with CDT dental procedure codes must be submitted as an ASC X12/005010X224A2 Health Care Claim: Dental (837) transaction to Highmark's dental associate, United Concordia Dental (UCD). Oral surgery services that are reported with CPT medical procedure codes must be submitted as a Health Care Claim: Professional (837P) transaction to either Highmark or UCD according to which payer is responsible for the patient's oral surgery coverage.

Claims Resubmission

Frequency Type codes that tie to "prior claims" or "finalized claims" refer to a previous claim that has completed processing in the payer's system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claim”. An 837 is not an appropriate response to a payer’s request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.2 005010X223A2 Health Care Claim: Institutional (837I)

The 837 transaction is used for institutional claims. The May 2006 ASC X12 005010X223 Implementation Guide, as modified by the August 2007 and the June 2010 Type 1 Errata documents, is the primary source for definitions, data usage, and requirements. Transactions must be submitted with the revisions in the errata; the transaction version must be identified as 005010X223A2.

Companion guides supplement the national guide and addenda with clarifications and payer-specific usage and content requirements. This section and the corresponding transaction detail make up the companion guide for submitting Health Care Claim: Institutional (837I) claims for patients with Highmark Western and Northeastern New York benefit plans.

Patient with Coverage from another Out-of-State Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept Health Care Claim: Institutional (837I) claims when the patient has coverage from an out-of-state plan. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha/numeric prefix. Also, the appropriate Highmark payer must be listed as the payer by submitting Highmark Western and Northeastern New York’s NAIC 55204 in the GS03 Application Receiver’s Code and the loop 2010BB NM109 Payer ID. Highmark will use the Member ID alpha/numeric prefix to identify the need to coordinate processing with another Plan. If the alpha/numeric prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local Highmark Western and Northeastern New York member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark’s system, the claim would be denied for no coverage and any payment due the facility would be delayed until the claim is corrected and resubmitted.

This operating arrangement allows Highmark Western and Northeastern New York to be an electronic interface for its local providers to out-of-state Plans that are licensees of the Blue Cross Blue Shield Association. Any payment to the provider will be made by Highmark.

Claims Resubmission

Frequency Type codes that tie to “prior claims” or “finalized claims” refer to a previous claim that has completed processing in the payer’s system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claim”. An 837 is not an appropriate response to a payer’s request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

7.3 005010X214 Health Care Claim Acknowledgment (277CA)

The 277 Claim Acknowledgment (277CA) transaction is a business application level acknowledgment for the Health Care Claim (837) transaction(s). This transaction acknowledges the validity and acceptability of claims for adjudication. The January 2007 ASC X12 005010X214 Implementation Guide is the primary source for definitions, data usage, and requirements.

Timeframe for Batch Health Care Claim Acknowledgment (277CA)

Generally, batch claim submitters should expect a Health Care Claim Acknowledgment (277CA) within twenty-four hours after Highmark receives the electronic claims, subject to processing cutoffs. The 277CA files (ISA-IEA) will be grouped by the 277CA transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837. Each 277CA grouping (GS-GE) will be in a separate file (ISA-IEA). For example, if an 837 file (ISA – IEA) has 2 Functional Groups (GS-GE) and each Functional Group has 2 837 transactions (ST-SE), there will be two 277CA files (ISA-IEA) each with a Functional Group that contains two 277CA transactions (ST-SE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

There is a one-to-one relationship between an 837 (ST-SE) and the corresponding 277CA (ST-SE).

In the event system issues are encountered and all claims from a single 837 transaction cannot be acknowledged in a single 277CA, it may be necessary to retrieve multiple 277CA transactions related to an electronic claims transaction. See section 4.4 Communication Protocol Specifications information on retrieving the batch Health Care Claim Acknowledgment (277CA).

7.4 005010X221A1 Health Care Claim Payment/Advice (835)

The 835 transaction is used to provide an explanation of claims payment. The April 2006 ASC X12 005010X221 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the June 2010 Addenda document is the primary source for definitions, data usage, and requirements.

Availability of Payment Cycle 835 Transactions (Batch)

Payment Health Care Claim Payment/Advice (835) transactions are created on a weekly or daily basis to correspond with Highmark's weekly or daily payment cycles. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete and remain available for 7 days.

Re-association of the 835 and EFT payment

Providers have the ability to automate their patient account posting and reconciliation with the associated electronic payment, through use of an Electronic Remittance Advice (ERA/835) and Electronic Funds Transfer (EFT). Providers who receive payment for claims via EFT and also receive the 835 transactions must contact their financial institution to arrange for the delivery of the EFT payment data that is needed for re-association of the payment and the 835. The table below defines the payment data needed for reassociation and where that data is located in both the banking system's CCD+ (EFT) format file and the 835 Transaction:

EFT Payment Data	Banking System's CCD+ Format File	835 Transaction Data
Effective Entry Date	Record 5, Field 9	BPR16
EFT Amount	Record 6, Field 6	BPR02
Payment Related Information	Record 7, Field 3	TRN Segment (Payment/EFT Trace Number)

Missing or Late 835 or EFT Payment

If an **ERA/835** file has not been received after 4 business days of receipt of the corresponding EFT payment, you can research it by contacting EDI Operations.

If an **EFT** payment has not been received after 4 business days of receipt of the corresponding ERA/ 835 file, you can research it by contacting Provider Service.

Highmark defines business days as Monday through Friday, excluding holidays. A holiday schedule is published on a yearly basis. For Electronic Funds Transfer (EFT), Highmark follows the bank holiday schedule. The electronic funds will be available the next business day following the bank holiday.

Limitations

- Paper claims may not provide all data utilized in the Health Care Claim Payment/Advice (835). Therefore, some data segments and elements may be populated with "default data" or not available as a result of the claim submission mode.
- Administrative checks are issued from a manual process and are not part of the weekly or daily payment cycles; therefore, they will not be included in the Health Care Claim Payment/Advice (835) transaction. A letter or some form of documentation usually accompanies the check. An administrative check does not routinely contain an Explanation of Benefits notice.

- The following information will be populated with data from internal databases:

  Payer name and address

  Payee name and address

Highmark Western and Northeastern New York Major Medical

Under certain group contracts, Highmark processes major medical benefits concurrently with the “basic” medical-surgical coverage. In those instances, the liabilities for the “basic” coverage and the major medical coverage will be combined and the resulting “net” liabilities will be reported in the Claim Adjustment Segment at either the claim level or each service line, depending on the type of claim. Claims that are processed concurrently with major medical coverage will reflect Remittance Advice Remark Code ‘N7 - Processing of this claim/service has included consideration under Major Medical provisions’ in either the 2100 Loop MIA or MOA Segment or 2110 Loop LQ Segment to alert the provider of this processing arrangement.

Claim Overpayment Refunds

Professional and Facility Claims

When overpayment of a professional claim is identified by the provider, and verified by Highmark, the reversal/correction/offset mechanism described above for member facility institutional claims is followed.

When overpayment of a professional claim is identified by Highmark, the provider’s payment will not be reduced by the overpayment amount until 60 days after the reversal and correction claims appear on the Health Care Claim Payment/Advice (835). This delay is intended as an opportunity for the provider to appeal Highmark’s overpayment determination. Due to timing of the appeal review and actual check/ EFT reduction, providers are encouraged to NOT wait until the 60-day limit approaches to appeal the refund request. With the exception of difficult refund cases, this new process will eliminate the form letters providers receive from Highmark that contain the details of an overpayment.

In the Health Care Claim Payment/Advice (835) transaction, the Highmark-identified overpayment reversal and correction claims with a 60-day delay to offsets will be separated to a second LX loop (LX01 = 2). Because the resulting overpayment amounts for the claims in this LX loop are not being deducted from this check/EFT, a negative amount which cancels out the reversal and correction overpayment claims is reported in the Provider Adjustment PLB segment. The PLB segment will have the following codes and information:

- Provider Adjustment Reason Code WO, Overpayment Recovery.
- Reference Identification will contain the claim number from the reversal and correction claim followed by the word “DEFER” with no space. Example: ‘06123456789DEFER.’

Claim Interest – If an interest payment was made in connection with the original claim payment, recoupment of the interest corresponding to the overpayment will also be deferred. Deferred Interest will be individually detailed in the PLB Segment to assist the provider with account reconciliation. The PLB Segment will reflect the following codes and information:

- Provider Adjustment Reason Code L6, Interest Owed
- Reference Identification will contain the claim number from the impacted claim followed by the word “DEFER” with no space. Example: ‘06123456789DEFER.’
- Both a positive and negative interest (L6) adjustment will be shown in order to not financially impact the current Health Care Claim Payment/Advice (835) payment.

If an appeal is not filed before the 60-day review period expires, Highmark will assume the provider agrees with the refund request. The overpayment refund will then be deducted from a current check/EFT, and that refund amount will be reflected in a Provider Adjustment PLB segment. Note that the reversal and correction claim detail is not repeated in the Health Care Claim Payment/Advice (835) after the 60-day review period. The following codes and information will be used in the PLB segment for this purpose:

- Provider Adjustment Reason Code WO, Overpayment Recovery.
- Reference Identification will contain the claim number from the reversal and correction claim.
- If Interest related to this claim was previously deferred, the current refund amount being collected will include the interest amount.

In the event the full refund amount cannot be deducted from the current check/EFT, then the remaining balance will be 'moved forward' to a subsequent check/EFT using the Provider Adjustment Reason code of FB – Forward Balance in the Provider Adjustment PLB segment of the Health Care Claim Payment/Advice (835).

Highmark uses the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing

Provider Payments from Member Health Care Accounts

Highmark Western and Northeastern New York members under certain health care programs have the option to have their member liability paid directly to the provider from their health care spending account. The member health care spending accounts include Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA). Additional information regarding this option and the specific programs impacted was sent to providers and facilities.

Highmark will create a separate batch or payment Health Care Claim Payment/Advice (835) transaction (ST to SE Segment) to document the payment from the member's saving/ spending account. This separate or second Health Care Claim Payment/Advice (835) reporting methodology is termed a "COB reporting model" meaning the member spending account Health Care Claim Payment/Advice (835) will have the code value attributes of a secondary claim payment. This is a Health Care Claim Payment/Advice (835) reporting model or methodology, designed to utilize existing automated account posting software functionality and is NOT considered to be the same as a true Payer to Payer COB process for claim adjudication. Highmark will continue to create a Health

Care Claim Payment/Advice (835) transaction to document Highmark's payment. If the member has a saving/spending account, has selected the payment to provider option and has funds available in the account, Highmark will create another Health Care Claim Payment/Advice (835) transaction to document how the remaining liabilities were addressed by the payment from the member's account. The additional Health Care Claim Payment/Advice (835) transaction, containing members' health care account payments, will have the same structure as the Health Care Claim Payment/Advice (835) transactions Highmark currently produces. The health care account Health Care Claim Payment/Advice (835) transactions (ST to SE Segments) will be included in the Trading Partner's transmission file (ISA to IEA Segments) currently produced for Highmark. Trading Partners will be able to distinguish the health care account Health Care Claim Payment/Advice (835) by the following features:

- Loop 1000A, N102 – The Payer Name will be 'Highmark Western and Northeastern New York Health Care Account.'
- Loop 2100, CLP02 – The Claim Status Code for all claims contained in the 835 transaction will equal '2 – Processed as secondary.'
- Loop 2100 or Loop 2110, CAS Segment – The Claim Adjustment Group and Reason Code will be OA23 for all dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.

Example: Health Care Claim Payment/Advice (835) Segments Documenting Payment from Highmark and Payment from the Member's Account

The example below illustrates the 'COB reporting model' and Health Care Claim Payment/Advice (835) segments documenting claim payment from Highmark under the patient's health care coverage plan and reimbursement from the patient's health care account. For purposes of ERA reporting only, Highmark's payment will be treated as 'primary' and payment from the member's health care account as 'secondary'.

In this example, the provider's charge is $200. The Highmark allowance for the procedure is $180, leaving a contractual obligation of $20. Highmark applies $130 of that amount to the patient’s deductible and pays the remaining $50 to the provider. This is spelled out in the “primary” example below, on the left.

The right side of the example below displays an accounting of the way the member liabilities were handled through the member’s saving/ spending account, as it would appear on the Health Care Claim Payment/Advice (835) transaction. The entire patient deductible of $130 is being reimbursed by the member’s health care account. The $70 difference ($20 Contractual Obligation plus $50 paid by Highmark) between the $200 charge and the $130 payment from the member’s account was assigned a Claim Adjustment Group and Reason code of OA23 – “Other Adjustment/Payment adjusted due to the impact of prior payer(s) adjudication, including payments and/or adjustments.”

See the example below:

Highmark (Primary)	**Health Care Account Payment (Secondary**
N1^PR^HIGHMARK~ CLP^ABC123^1^200^50^130^12^0123456789~ NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ SVC^HC>99245^200^50~ DTM^150^20090301~ DTM^151^20090304~ CAS^CO^45^20~ CAS^PR^1^130~	N1^PR^HIGHMARK HEALTH CARE ACCOUNT~ CLP^ABC123^2^200^130^^12^0123456789~ NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ SVC^HC>99245^200^130~ DTM^150^20090301~ DTM^151^20090304~ CAS^OA^23^70~

7.5 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Action on a Functional Group can be: acceptance, partial acceptance, or rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in IK501.) The location and reason for errors are identified in one or more of the following segments:

IK3 - segment errors
IK4 - data element errors
IK5 - transaction errors
AK9 - functional group errors

Rejection codes are contained in the ASC X12C 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) national Implementation Guide. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA - IEA) and Functional Group (GS - GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be "005010x231A1". Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. The GS08 value from the originally submitted transaction resides in the AK103 of the Implementation Acknowledgment for Health Care Insurance (999) guide.

As part of your trading partner agreement, values were supplied that identify you as the submitting entity. If any of the values supplied within the envelopes of the submitted transaction do not match the values supplied in the trading partner agreement, a rejected Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter. In the following example the IK404 value ‘TRADING PARTNER PROFILE’ indicates that one or more incorrect values were submitted. In order to process your submission, these values must be corrected and the transaction resubmitted.

```
ISA^00^          ^00^          ^33^55204          ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03
IK3^GS^114^^8
IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
```

7.6 Healthcare Claim--Medicaid Recoupment

In order for Highmark to establish an entity as a Medicaid Recoupment Trading Partner, they must first provide a Letter of Authority (LOA) confirming they are authorized to recoup Medicaid paid money on behalf of the Medicaid agency and the Medicaid agency must be credentialed with Highmark's Provider Information Management (PIM) area as a government billing entity. Once the LOA is confirmed and the credentialing process is complete, a Trading Partner can request to be set up for Medicaid Recoupment by contacting EDI Operations at 1-800992-0246. If submitting through an established Highmark Trading Partner, a new Trading Partner will need to be set up to segregate recoupment from the commercial line of business, due to Highmark's business operating rules.

Below is a summary of requirements for billing Medicaid Recoupment claims via EDI 837 claim transaction:

1. BHT06 = 31 (identifies "Subrogation Demand")
2. Inclusion of **Loop ID-2010AC Pay-to Plan Name Loop**. Highmark Medicaid Government issued Agency number will be sent in the NM109 (Only used when BHT06=31)
3. The Medicaid paid amount, indicated in Loop ID-2320 (claim level) and Loop ID- 2430 (Line level) data element AMT02, represents the maximum amount of liability the Medicaid agency is requesting to recover by submitting the claim. AMT01=D
4. The Medicaid agency is identified in Loop ID-2330B (Other Payer Name).
5. Loop ID-2320 (claim level) and Loop ID-2430 (line level) include all required segments to indicate the Medicaid agency's adjudication of the original claim submitted to that agency.

Please refer to Section 1.4.1.5 Coordination of Benefits - Medicaid Subrogation of the HIPAA Implementation guide.

7.7 Additional Information to Support a Health Care Claim Attachment (275CA)

The Additional Information to Support a Health Care Claim Attachment transaction is utilized by providers and facilities to send additional information about a claim. For Highmark's purposes the Claim Attachment version of this transaction will be referred to as 275CA. The use of this transaction is designed to assist those who are submitting unsolicited supporting information about a health care claim (837) using the 275 format. The February 2008 ASC X12 005010X210 Implementation Guide is the primary source for definitions, data usage and requirements. This section and the corresponding transaction data detail make up the companion guide for submitting Additional Information to Support a Health Care Claim Attachment (275CA) for patients with Highmark benefit plans, Federal Employees Health Benefit Plan and BlueCard Par Point of Service (POS).
Accurate reporting of Highmark's NAIC code is critical for 275 transactions submitted to Highmark.

8. Acknowledgments and Reports

8.1 Report Inventory

Highmark has no proprietary reports.

8.2 ASC X12 Acknowledgments

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance
277 Acknowledgment	Claim Acknowledgment to the Electronic Claim

Outgoing Interchange Acknowledgment TA1 Segment

Highmark returns a TA1 Interchange Acknowledgment segment in batch mode when the entire interchange (ISA - IEA) must be rejected.

The interchange rejection reason is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the guidelines in the 999 Implementation Guide. Each Highmark TA1 will have an Interchange control envelope (ISA - IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Transaction accepted/rejected status is indicated in IK501. For details on this transaction, please refer to the Implementation Acknowledgment for Health Care Insurance (999) in Sections 7.8 and 10 of this Companion Guide.

Outgoing Claim Acknowledgment (277CA Transaction)

The Claim Acknowledgment Transaction is used to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the electronic claim transaction in batch mode. The 277CA files (ISA-IEA) will be grouped by the 277CA transactions (ST-SE) within the same Functional Grouping (GS-GE) that was submitted on the corresponding 837. Each 277CA grouping (GS-GE) will be in a separate file (ISA-IEA). For example, if an 837 file (ISA – IEA) has 2 Functional Groups (GS-GE) and each Functional Group has 2 837 transactions (ST-SE), there will be two 277CA files (ISA-IEA) each with a Functional Group that contains two 277CA transactions (STSE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

9. Trading Partner Agreements

Provider Trading Partner Agreement ( )
For use by professionals and institutional providers.

Clearinghouse/vendor Trading Partner Agreement ( )
For use by software vendors, billing services or clearinghouses.

TRADING PARTNERS

An EDI Trading Partner is defined as any customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

10. Transaction Specific Information

This section describes how ASC X12 Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Highmark Western and Northeastern New York has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Highmark

In addition to the row for each segment, one or more additional rows are used to describe Highmark's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

This lists the X12 Implementation Guides for which specific transaction instructions apply and which are included in Section 10 of this document.

Unique ID	**Name**
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010X221A1	Health Care Claim Payment/ Advice
005010X231A1	Implementation Acknowledgment for Health Care Insurance

005010X222A1 Health Care Claim: Professional (837P)

Refer to section 7.1 for Highmark Business Rules and Limitations

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	55204	Highmark Western and Northeastern New York
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		Highmark will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		Highmark Western and Northeastern New York
	NM109	Receiver Primary Identifier	55204	Identifies Highmark Western and Northeastern New York as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	N3	Billing Provider Address		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		Highmark will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For Highmark claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which Highmark does not process.
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha/numeric characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BA	REF	Subscriber Secondary Identification		Highmark does not need secondary identification to identify the subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		Highmark Western and Northeastern New York
	NM109	Payer Identifier	55204	Highmark Western and Northeastern New York
2010BB	REF	Payer Secondary Identification		Highmark does not need secondary identification to identify the payer.
2300	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.

005010X222A1 Health Care Claim: Professional				
Loop ID	Reference	Name	Codes	Notes/Comments
2300	PWK	Claim Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be printed from: https://edi.highmark.com/edi-ny
				4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.
2300	NTE	Claim Note		For fastest processing of anesthesia claims where the surgery procedure code reported in the Anesthesia Related Procedure HI segment is a Not Otherwise Classified code, report a complete description of the surgical services in this NTE segment.
2300	CR2	Spinal Manipulation Information		This segment is not needed for the payer's adjudication process; therefore, the segment is not required.
2300	CRC	Patient Condition Information: Vision		This segment is not needed for the payer's adjudication process; therefore, the segment is not required.
2300	HI	Anesthesia Related procedure		Send the procedure code for the surgery or other service related to the anesthesia, if known.
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2310C	N3	Service Facility Location Address		When the 2310C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.
2310C	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2400	SV1	Service Line		
	SV101-1	Product / Service ID Qualifier		1) Qualifier value HC, HCPCS, is the only value Highmark will accept in this element. 2) CDT dental codes (codes starting with a D) should be submitted in an 837-Dental transaction. Dental codes are not considered valid with an HC, HCPCS qualifier in an 837 Professional Claim transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2400	PWK	Line Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be printed from: https://edi.highmark.com/edi-ny 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode.
	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.
2400	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.
2400	AMT	Sales Tax Amount		This amount is not needed for the payer's adjudication process; therefore, the amount is not required.
2400	PS1	Purchase Service Information		This information is not needed for the payer's adjudication process; therefore, it is not required.
2410	LIN	Drug Identification		**1.** NDC codes are required when specified in the Provider's agreement with Highmark. **2.** Highmark encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark
2420C	N3	Service Facility Location Address		When the 2420C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.

005010X223A2 Health Care Claim: Institutional (837I)

Refer to section 7.2 for Highmark Business Rules and Limitations

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	55204	Highmark Western and Northeastern New York
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		Highmark will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		Highmark Western and Northeastern New York
	NM109	Receiver Primary Identifier	55204	Identifies Highmark Western and Northeastern New York as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010AA	N3	Billing Provider Address		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		Highmark will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For Highmark claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which Highmark does not process.
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha/numeric characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BA	REF	Subscriber Secondary Identification		Highmark does not need secondary identification to identify the subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		Highmark Western and Northeastern New York
	NM109	Payer Identifier	55204	Highmark Western and Northeastern New York

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BB	REF	Payer Secondary Identification		Highmark does not need secondary identification to identify the payer.
2300	CLM	Claim Information		
	CLM05-1	Facility Type Code	84	Highmark considers Free Standing Birthing Center to be Outpatient when applying data edits. Note that this is a variation from the Inpatient indication in the NUBC Data Specifications Manual as of the time of this document.
2300	DTP	Discharge Hour		
	DTP03	Discharge Time		Hours (HH) are expressed as '00' for midnight‘, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	DTP	Admission Date/Hour		
	DTP03	Admission Date and Hour		Hours (HH) are expressed as '00' for midnight‘, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'..

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	PWK	Claim Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be printed from https://edi.highmark.com/edi-ny 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode.
	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.
2300	HI	Principle Procedure Code		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.
	HI01-1	Code List Qualifier Code		Until further notification from Highmark, Advanced Billing Concepts (ABC) codes will not be accepted.
2310A	PRV	Attending Provider Specialty Information		When the Attending Provider's National Provider Identifier (NPI) is associated with more than one Highmark contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2310E	N3	Service Facility Location Address		When the 2310E Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox or similar delivery points that cannot be the service location will not be accepted in this segment.
2310E	N4	Service Facility Location City/State/Zip		
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.
2330B	NM1	Other Payer Name		

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2400	PWK	Line Supplemental Information		1. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. 2. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. 3. A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. The cover sheet form can be printed from: https://edi.highmark.com/edi-ny 4. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode.
	PWK01	Attachment Type Code		Highmark may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PWK02	Attachment Transmission Code	AA (Available on Request) BM (By mail) FX (By fax)	Highmark's business practices and policy only support the listed transmission types at this time.

005010X214 Health Care Claim Acknowledgment (277CA)

Refer to section 7.3 for Highmark Business Rules and Limitations

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	55204	This will match the payer id in the GS03 of the claim transaction Highmark Western and Northeastern New York
	GS03	Application Receiver's Code		This will always be the Highmark assigned Trading Partner Number for the entity receiving this transaction.
2100A	NM1	Information Source Name		
	NM109	Information Source Identifier	55204	This will match the payer id in the GS03 of the claim transaction Highmark Western and Northeastern New York
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the Highmark assigned Trading Partner Number for the entity that submitted the original 837 transaction.
2200B	STC	Information Receiver Status Information		Status at this level will always acknowledge receipt of the claim transaction by the payer. It does not mean all of the claims have been accepted for processing. We will not report rejected claims at this level.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level.
	STC01-2	Health Care Claim Status Code	19	Default value for this status level.
	STC01-3	Entity Identifier Code	PR	Default value for this status level.
	STC03	Action Code	WQ	This element will always be set to WQ to represent Transaction Level acceptance. Claim specific rejections and acceptance will be reported in Loop 2200D.
	STC04	Total Submitted Charges		In most instances this will be the sum of all claim dollars (CLM02) from the 837 being acknowledged. In instances where the claim dollars do not match, an exception process occurred. See Section 7.3 about the exception process.
2200C		Provider of Service Information Trace Identifier		The 2200C loop will not be used. Status or claim totals will not be provided at the provider level.
2200D	STC	Claim Level Status Information		Relational edits between claim and line level data will be reported at the service level
	STC01-2	Health Care Claim Status Code	247	Health Care Claim Status Code '247 - Line Information' will be used at the claim level when the reason for the rejection is line specific.
2200D	DTP	Claim Level Service Date		
	DTP02	Date Time Period Format	RD8	RD8 will always be used.
	DTP03	Claim Service Period		The earliest and latest service line dates will be used as the claim level range date for professional claims. When the service line is a single date of service, the same date will be used for the range date.
2220D	STC	Service Line Level Status Information		Relational edits between claim and line level data will be reported at the service level
2220D	DTP	Service Line Date		.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP02	Date Time Period Format	RD8	RD8 will always be used
	DTP03	Service Line Date		When the service line date is a single date of service the same date will be used for the range date

005010X221A1 Health Care Claim Payment/ Advice (835)

Refer to section 7.4 for Highmark Business Rules and Limitations

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender’s Code	55204	This will match the payer id in the GS03 of the claim transaction Highmark Western and Northeastern New York
	GS03	Application Receiver’s Code		This will always be the Highmark assigned Trading Partner Number for the entity receiving this transaction.
	REF	Receiver Identification		
	REF02	Receiver Identification		This will be the electronic Trading Partner Number assigned by Highmark’s EDI Operations for transmission of Health Care Claim Payment/ Advice (835) transactions
1000A	N1	Payer Identification		
	N102	Payer Name	HIGHMARK NY HIGHMARK HEALTH CARE ACCOUNT	**Highmark NY** is used for payments from non-healthcare spending accounts. **Highmark Healthcare Account** is used for payments from healthcare spending accounts.
1000A	REF	Additional Payer Identification		
	REF01	Reference Identification Qualifier	NF	This value will always be used.
	REF02	Additional Payer Identification	55204	Highmark Western and Northeastern New York
1000A	PER	Payer Web Site		Highmark will not be using the Payer Web Site Segment
1000B	REF	Additional Payee Identification		
	REF01	Additional Payee Identification Qualifier	TJ	The Provider’s Tax Identification Number will be sent when the Provider’s NPI is sent in the 1000B Payee Identification N104.
2000	LX	Header Number		A number assigned for the purpose of identifying a sorted group of claims.

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	LX01	Assigned Number	1	All claims except Highmark Identified Overpayment reversal and correction claims where refund offset is delayed for 60-day review period.
	LX01	Assigned Number	2	Highmark Identified Overpayment reversal and correction claims where refund offset is delayed for 60-day review period. Refer to section 7.4 of this document for further information.
2100	CLP	Claim Payment Information		
	CLP01	Claim Submitter’s Identifier		The actual Patient Account Number may not be passed from paper claim submissions.
	CLP02	Claim Status Code	2	**Health Care Spending Account use:** This status code will be used on all claims within a Health Care Claim Payment/ Advice (835) that contains claim payments from members'' Health Care Spending Accounts. Refer to Section 7.4 for more information.
2100	CAS	Claim Adjustment		
	CAS01	Claim Adjustment Group Code	OA	**Health Care Spending Account use**: This Group Code will be used for all adjustment dollars that equal the difference between the provider’s charge and the Patient Responsibility dollars being considered for reimbursement under the account.
	CAS02	Claim Adjustment Reason Code	23	**Health Care Spending Account use:** This Reason Code will be used for all adjustment dollars that equal the difference between the provider’s charge and the Patient Responsibility dollars being considered for reimbursement under the account.
2100	NM1	Crossover Carrier Name		This segment will only be used to report a 'Blue on Blue' Coordination of Benefits coverage situation. In this situation, Highmark will indicate the claim has been processed by Highmark and is being transferred to a second Highmark coverage.
2100	NM1	Corrected Priority Payer Name		

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM108	Identification Code Qualifier	PI	Highmark will always use this value
	NM109	Identification Code		Other payer IDs are not currently retained therefore a default value of **99999** will be used in this element.
2100	REF	Other Claim Related Identification		
	REF01	Reference Identification Qualifier	CE	
	REF02	Other Claim Related Identifier		Professional claims - This value will be utilized to provide the payer's Class of Contract Code and code description. Institutional claims - This value will be utilized to provide the Reimbursement Method Code.
2110	SVC	Service Payment Information		
	SVC01-2	Adjudicated Procedure Code		The applicable Unlisted Code will be returned in this data element when a paper professional or institutional claim was submitted without a valid procedure or revenue code: 99199 - Unlisted HCPCS Procedure code (SVC01-1 qualifier is HC) 0949 - Unlisted Revenue code (SVC01-1 qualifier is NU)
	SVC03	Line-Item Provider Payment Amount		
2110	CAS	Service Adjustment		
	CAS01	Claim Adjustment Group Code	OA	
	CAS02	Claim Adjustment Reason Code		Refer to WPC-EDI
2110	REF	Healthcare Policy Identification		Highmark will not be using the Healthcare Policy Identification Segment
	PLB	Provider Adjustment		

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	CS	This value will be used for financial arrangement adjustments such as Bulk Adjustments, Cost Rate Adjustments, etc. Supporting identification information will be provided in the Reference Identification element.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	FB	This value will be used to reflect balance forward refund amounts between weekly Health Care Claim Payment/ Advice (835) transactions. Refer to Section 7.4 for more information.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	L6	This value will be used to reflect the interest paid or refunded for penalties incurred as a result of legislated guidelines for timely claim processing. Refer to Section 7.4 for more information on interest related to deferred refunds.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	WO	This value will be used for recouping claim overpayments and reporting offset dollar amounts. Refer to Section 7.4 for more information
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Provider Adjustment Reason Code is "FB" the Provider Adjustment Identifier will contain the applicable 835 Identifier as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	Reference	Name	Codes	Notes/Comments
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Adjustment Reason Code is ”WO", the Provider Adjustment Identifier will contain the Highmark Claim Number for the claim associated to this refund recovery. For Highmark identified overpayments, the claim number will be followed by the word "DEFER" (example: 06123456789DEFER) when the reversal and correction claims are shown on the current Health Care Claim Payment/ Advice (835) but the refund amount will not be deducted until after the 60 day appeal period Refer to Section 7.4 for more information on Claim Overpayment Refunds.

005010X212 Health Care Claim Status Request and Response (276/277)

Not supported at this time.

005010279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

Not supported at this time.

005010X217 Health Care Services Review-Request for Review and Response (278)

Not supported at this time.

005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Refer to section 7.5 for Highmark Business Rules and Limitations

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		Highmark has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		Highmark has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		
	IK404	Copy of Bad Data Element		The 005010 version of the 999 transaction does not support codes for errors in the GS segment, therefore, when there are errors in the submitted GS, “TRADING PARTNER PROFILE” will be placed in this element to indicate that one or more invalid values were submitted in the GS.
2110	CTX	Element Context		Highmark has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time

005010X210 Additional Information to Support a Healthcare Claim attachment (275CA)

Refer to section 7.7 for Highmark Business Rules and Limitations

005010X210 Additional Information to Support a Healthcare Claim Attachment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		The receiver's Highmark-assigned Trading Partner Number will be used.
	GS03	Application Receiver's Code	55204	To support Highmark's routing process, all claims in a functional group should be for the same payer. Submit the NAIC code for the payer identified in the claim. Highmark Western and Northeastern New York
	BGN			
	BGN01	Transaction Set Purpose Code	02	Used when submitting an attachment to an unsolicited 837
1000A	NM1	Payer Name Information		
	NM101	Entity Identifier Code	PR	Payer
	NM102	Entity Type Qualifier	2	Non-Person
	NM103	Organization Name		Highmark Western and Northeastern New York
	NM108	Identification Code Qualifier	PI	Payer Identifier

	NM109	Identification Code	55204	Highmark Western and Northeastern New York
2000A	TRN	Attachment Control Number		
	TRN02	Reference Identification		This value should be the Payer Claim Control Number

Appendices

1. Implementation Checklist

Highmark does not have an Implementation Checklist.

2. Business Scenarios

No Business Scenarios at this time.

3. Transmission Examples

No examples at this time.

4. Frequently Asked Questions

No FAQs at this time

5. Change Summary

The items below were revised from the April 2025 version to this January 2026 version of the Provider Companion Guide.

Page	Section	Description
	Multiple	Added 275 CA