Highmark

HIPAA Transaction
Standard Companion Guide

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

October 2023

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 Inc. (Highmark). 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. 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 customer (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 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's EDI Companion guidelines for development of the EDI transactions. These documents may be accessed through Highmark's EDI Trading Partner Portal:

https://edi.highmark.com/edi/resources/guides/index.shtml

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.

Provider Information Management

To obtain the status of a provider's application for participation with any Highmark provider network, please contact Provider Data Services at (866) 763-3224 (option 4). Also, use this number to update provider data currently on file with Highmark. Note that this number only serves Highmark networks; provider data for other payers mentioned in this guide for EDI transactions must be communicated as established by those other payers.

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)

These five 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, in writing via email, the Trading Partner to submit 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.

Resource Center https://edi.highmark.com/edi/resources/guides/index.shtml

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 'ERA Enrollment Form' on the Update Trading Partners section of the site.

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 Affiliations Application on the Update Trading Partners section and select the option to “Add a provider to an existing Trading Partner”.

Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should complete a Provider Change request on the Update Trading Partners section of the Trading Partner web site.

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/resources/guides/index.shtml

Out of State Providers

Due to an operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association, Highmark cannot accept electronic transactions from out of state nonparticipating/out-of-network providers for Highmark members. Providers should submit all Blue Cross Blue Shield electronic claims[1] and inquiry 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 transaction files to our production environment. A TA1 will be generated for any transaction file that has “test” indicated in the ISA15 element.

Inquiry Transactions

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

Real-Time Electronic Claim[1] Estimation Demonstration Process

Highmark’s real-time Electronic Claim[1] Estimation process does not impact or actually update the claim adjudication system with respect to a patient’s claim history, accumulated member liability, maximums, etc. Consequently, Professional and Institutional Trading Partners that want to test real-time electronic claim[1] capabilities will have to do so using the Electronic Claim[1] Estimation process.

Professional and Institutional Trading Partners have the ability to validate their secure Internet connection to Highmark, as well as submit an Electronic Claim[1] Estimation which will be edited for X12 syntax and Highmark business edits. If the Electronic Claim[1] Estimation passes the edits, member liability will be estimated with the end results being returned in a real-time Health Care Claim Payment/Advice (835) response.

- An Implementation Acknowledgment for Health Care Insurance (999) transaction will be returned in the event that a rejection occurs at the X12 syntax editing level.
- A Health Care Claim Acknowledgment (277CA) transaction will be returned in the event that a rejection occurs as a result of Highmark business editing. The Health Care Claim Acknowledgment (277CA) transaction will return actual editing results
- If the Electronic Claim Estimation transaction passes the X12 syntax and Highmark business level edits, a real-time Health Care Claim Payment/Advice (835) response containing the member’s estimated liability and provider’s estimated payment will be returned.

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

- In the event the Electronic Claim[1] Estimation cannot be finalized within the real- time process, an accepted Health Care Claim Acknowledgment (277CA) will be returned indicating the 'Estimation cannot be completed in real-time'.

In order to submit a real-time Electronic Claim[1] Estimation test transaction, the ISA15 value must be equal to a "T". For more information on HTTPS connectivity specifications for demonstration of Electronic Claim[1] Estimation submissions, refer to the Real-Time Claim Adjudication and Estimation Connectivity Specifications. These connectivity specifications are located in the Resources section under EDI Companion Guides at the following site:

https://edi.highmark.com/edi/resources/guides/index.shtml

3. Testing with the Payer

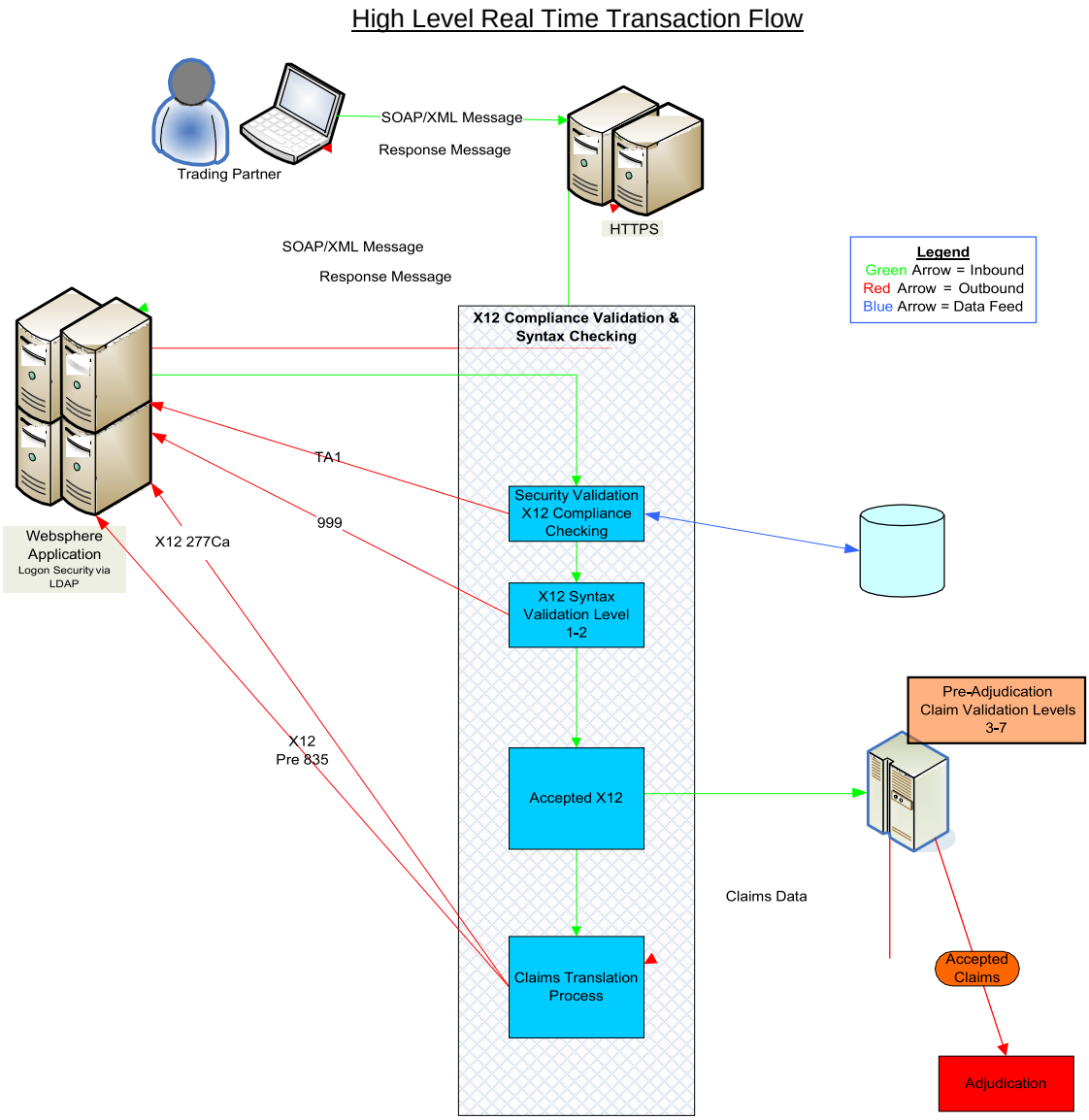
Highmark does not currently require or provide for the testing of any electronic claim or inquiry transactions. It is highly recommended, however, that all Practice Management Software (PMS) Vendors test their software for HIPAA compliance on behalf of all of their clients. Any questions about the requirements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

4. Connectivity with the Payer / Communications

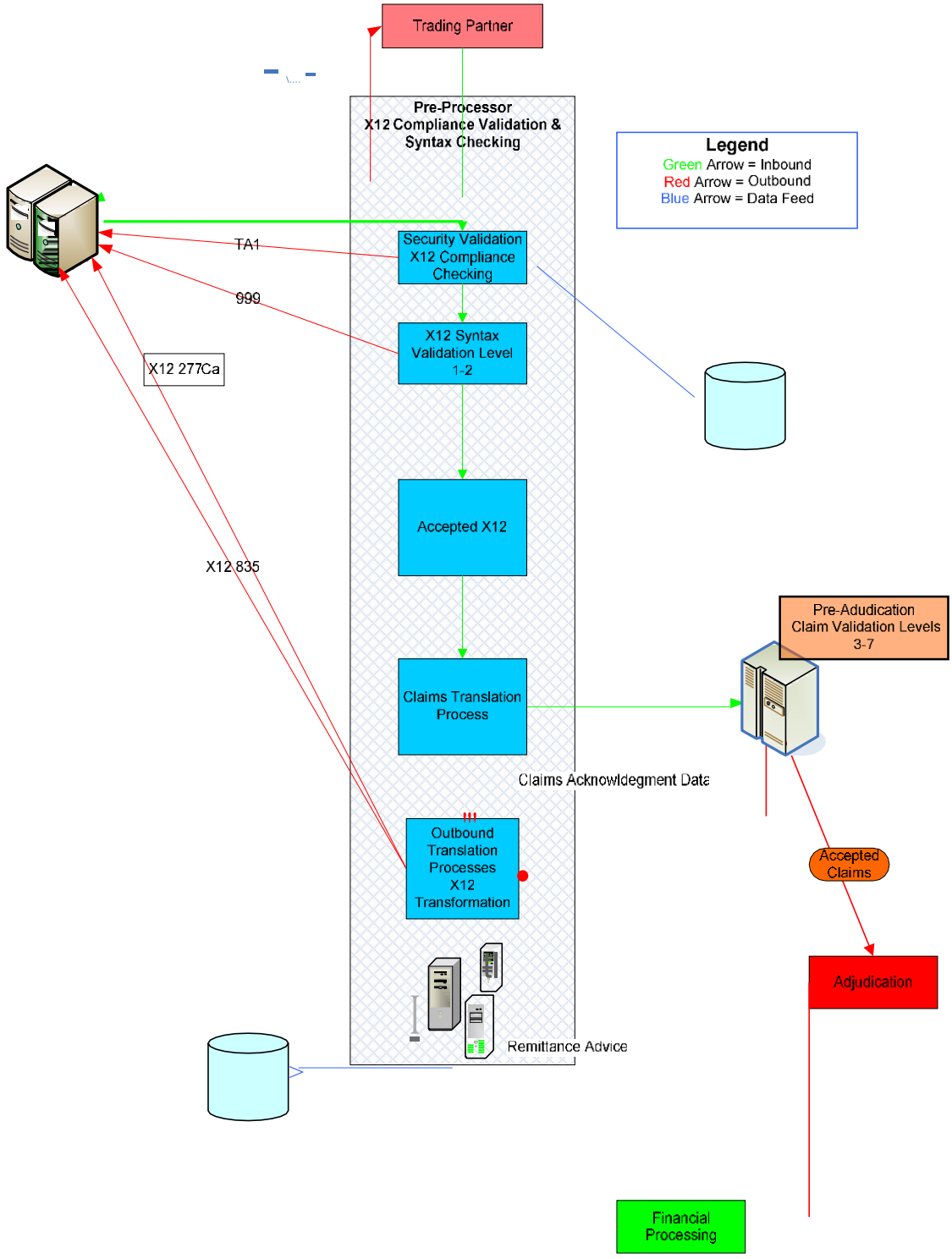
Highmark offers its Trading Partners two types of communication methods for transferring data electronically.

- Secure File Transfer Protocol (SFTP) through an Internet connection (Secure Transport) is available for transactions in batch mode.
- Hypertext Terminal Protocol Secure (HTTPS) through an Internet web service is available for transactions in real-time mode.

4.1 Process flows



High Level Batch Transaction Flow



4.2 Transmission Administrative Procedures

Real-Time Technical Connectivity Specifications

Highmark maintains separate specifications detailing the technical internet connectivity requirements for Highmark's real-time processes. These connectivity specifications are located in the Resources section under EDI Companion Guides at the following site:

https://edi.highmark.com/edi/resources/guides/index.shtml

For connectivity specifications related to the Request and Response Inquiry transactions (Health Care Eligibility Benefit Inquiry and Response (270/271), Health Care Claim Status Request and Response (276/277) and Services Review Request for Review/Response (278)), see the 'Real-Time Inquiry Connectivity Specifications'.

For connectivity specifications related to Claim Adjudication and Claim Estimation processes (Electronic Claim[1] / Health Care Claim

Payment/Advice (835)), including a complete Transaction Flow diagram, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications'.

Real-Time Claim Adjudication and Estimation

Highmark implemented real-time capability for claim adjudication and claim estimation. Both processes leverage the electronic claim[1] and Health Care Claim Payment/Advice (835) transactions for these business functions, as well as the Health Care Claim Acknowledgment (277CA) for specific situations.

Real-Time Adjudication – allows providers to submit an electronic claim[1] that is adjudicated in real-time and receive a response (Health Care Claim Payment/Advice (835)) at the point of service. This capability allows providers to accurately identify and collect member responsibility based on the finalized claim adjudication results.

Real-Time Estimation – allows providers to submit an electronic claim[1] for a proposed service and receive a response (Health Care Claim Payment/Advice (835)) in real-time. The response Health Care Claim

Payment/Advice (835) estimates the member responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.

[1] Electronic claim includes both ASC X1/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

For transaction specific information related to real-time claim adjudication and claim estimation capability, see the following sections of the Transaction Information Companion Guide:

7.1 – Health Care Claim: Professional (837P)
7.2 – Health Care Claim: Institutional (837I)
7.3 – Health Care Claim Acknowledgment (277CA)
7.4 – Health Care Claim Payment/Advice (835)

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 two methods to utilize the Internet for conducting electronic business with Highmark. The first is Secured File Transfer Protocol (SFTP) through "Secure Transport." "Secure Transport" is available for Trading Partners who submit or receive any HIPAA-compliant EDI transactions in batch mode. The second Internet-based service offers "Real-Time" capability for the following real-time enabled transactions:

- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Health Care Claim Status Request and Response (276/277)
- Health Care Services Review Request/Response – (278/278)
- Claim Adjudication or Estimation and Response – Electronic Claim[1]/ Health Care Claim Payment/Advice (835)

Internet File Transfer Protocol (SFTP) through "Secure Transport"

The Highmark Secure FTP Server ("Secure Transport") provides an SFTP 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 SFTP process in an encrypted and private manner.

Any state of the art browser can be used to access the Highmark Secure FTP Server. 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.

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

2. Connect to the SFTP 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[1] 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.

Internet/*Real*-Time (HTTPS- Hypertext Terminal Protocol Secure)

Highmark offers a Real-Time Web Service through a secure Internet connection (HTTPS) for our real-time enabled transactions:

Real-Time Inquiry Transactions

- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Claim Status Request/Response (276/277)
- Services Review Request for Review/Response (278)

Real-Time Claim Transactions

- Claim Adjudication or Estimation and Response Electronic Claim[1]/ Health Care Claim Payment/Advice (835)

Real-time inquiry transactions utilize a CORE-compliant Web Services Description Language (WSDL) Simple Object Access Protocol (SOAP). Whereas, Real-time claim transactions utilize a Highmark proprietary format SOAP. SOAP is a way for a program running in one kind of operating system to communicate with another operating system by using Extensible Markup Language (XML) for the exchange of information over the Internet. Since the Internet is being utilized to transport the data, encryption will be utilized to secure messages.

This Real-Time Web Service is designed to support interoperable machine-to-machine interaction over the Internet. In order to submit real-time transactions you will need a computer, a web server, Internet access and the ability to submit and receive HIPAA-compliant transactions using SOAP.

In order to take advantage of real-time transactions with Highmark, a Trading Partner will need to:

- Check with your EDI software vendor to ensure that the EDI transaction software is programmed for Highmark’s real-time CORE-compliant or proprietary SOAP transactions, as appropriate. For instructions on how to program for Highmark’s real-time transactions, refer to the “Real-Time Inquiry

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

Connectivity Specifications" or "Real-Time Claim Adjudication and Estimation Connectivity Specifications" in the Resources section under EDI Companion Guides at the following site:

https://edi.highmark.com/edi/resources/guides/index.shtml

- Complete an EDI Transaction Application
    - Select the real-time transaction option.
    - Include your email address.
    - Trading Partner must have a valid Internet enabled 'V' Logon ID. Real-time can be used with any existing 'V' Logon ID.
- Download the Web Services Security Certificate as outlined in appropriate Real-Time Connectivity Specification documents.

Real-time transactions are designed to respond to individual end-user requests for real-time enabled transactions.

Inquiry Transactions

For typical inquiry requests, the average response time should be within 15 seconds. Actual response time will be dependent upon real-time transaction activity. Batched inquiries should not be submitted through the real-time process as it may impact the response time.

Claim Adjudication or Estimation Transactions

Real-time claim adjudication or estimation transactions are designed to provide real-time processing and report the results via a Health Care Claim Payment/Advice (835) response. For typical claim requests, the average response time should be within 30 seconds. Actual response time will be dependent upon real-time transaction activity. Batched claim transmissions should not be submitted through the real-time process as they will receive a rejected Implementation Acknowledgment for Health Care Insurance (999).

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: (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 5:00 p.m. ET, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for EDI Operations:

TELEPHONE NUMBER: (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 5:00 p.m. ET, Monday through Friday.

5.3 Provider Service

Inquiries pertaining to Highmark Private Business Medical/Surgical or Dental claims should be directed to the appropriate Provider Service Department listed below:

Central Region	(866)	731-8080
Western Region	(800)	547-3627
Northeastern Region	(866)	731-8080

Southeastern Region	(866)	975-7290
FEP	(866)	763-3608
Dental (Commercial Products)	(800)	332-0366
Dental (TriCare Dental Programs)	(800)	866-8499
Davis Vision	(717)	302-5103

5.4 Applicable websites / e-mail

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

https://edi.highmark.com/edi/resources/guides/index.shtml

For instructions on how to program for Highmark's real-time transactions, refer to the "Real-Time Inquiry Connectivity Specifications" or "Real-Time Claim Adjudication and Estimation Connectivity Specifications" in the Resources section under EDI Companion Guides at the following site:

https://edi.highmark.com/edi/resources/guides/index.shtml

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 EDI Operations (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	54771 15460	Highmark Highmark Senior Health Company
	ISA13	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.
	ISA14	Acknowledgment Requested	1	Highmark always returns a TA1 segment when the incoming interchange is rejected due to errors at the interchange or functional group envelope.
	ISA15	Usage Indicator		Highmark uses the value in this element to determine

Loop ID	Reference	Name	Codes	Notes/Comments
				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	54771 15460	Highmark Highmark Senior Health Company
	ISA07	Interchange ID Qualifier	ZZ	Highmark will send qualifier code value "ZZ" Mutually Defined, to designate that a Highmark-assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The Highmark-assigned ID will be the trading partner's security login ID.

Loop ID	Reference	Name	Codes	Notes/Comments
				This ID will be left-justified and space filled.
	ISA14	Acknowledgment Requested		Highmark always uses a 0 (No Interchange Acknowledgement Requested).
	ISA15	Usage Indicator		Highmark provides T or P as appropriate to identify the test or production 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 for patients with Highmark benefit plans, Federal Employees Health Benefit Plan, Independence Blue Cross / Highmark joint products, and BlueCard Par Point of Service (POS). Accurate reporting of Highmark's NAIC code is critical for claims submitted to Highmark EDI.

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. BlueCard also applies in certain situations for patients with coverage from other Pennsylvania Plans, as detailed in the following subsections. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha prefix. Also, Highmark must be listed as the payer by submitting 54771 in the Application Receiver GS03 and in the loop 2010BB NM109 Payer ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with another Plan. If the alpha prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local Highmark 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 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.

First Priority Life Insurance Company (FPLIC) Out-of-Area Claims

Highmark is the electronic interface for FPLIC members' claims for providers outside the Blue Cross of Northeastern Pennsylvania (BCNEPA) 13 county service area who are not part of the FPLIC provider network. The BCNEPA service area includes the following counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming. These providers should send their electronic claims[1]for FPLIC members to Highmark EDI with Highmark listed as the payer. ("54771" in the NM109 Payer ID element of the 2010BB Payer Name loop) Highmark will use the Member ID alpha prefix to initiate coordinated processing (BlueCard process) with FPLIC. Processing results and any payment will be sent to the provider by Highmark.

Independence Administrators Out-of-Area Claims

Under the BlueCard operating arrangement described above, Highmark is the electronic interface to Independence Administrators for providers outside the Independence Blue Cross (IBC) 5 county service area that are not Personal Choice Network Providers. Highmark must be listed as the payer (accomplished by

reporting “54771” in the NM109 Payer ID element of the 2010BB Payer Name loop). Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with Independence Administrators. Any payment to the provider will be made by Highmark. The IBC service area includes the following counties: Philadelphia, Bucks, Chester, Delaware, and Montgomery.

Keystone Health Plan East (KHP East) Out-of-Area Claims

Under the BlueCard operating arrangement, providers outside the Independence Blue Cross (IBC) 5 county service area must list Highmark as the payer. This is accomplished by reporting “54771” in the NM109 Payer ID element of the 2010BB Payer Name loop. Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with KHP East. 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 Companies, Inc. (UCCI). 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 UCCI according to which payer is responsible for the patient’s oral surgery coverage.

Real-Time Claim Adjudication and Estimation

Highmark real-time claim adjudication and claim estimation processes leverage the Electronic Claim[1] transaction. The real-time Electronic Claim[1] applies the same business rules and edits as the batch Electronic Claim[1], with the exception of items listed below. Highmark requires that claims submitted for estimation be differentiated from claims submitted for adjudication within the SOAP of the HTTPS transmission protocol. For information on SOAP, connectivity and the related transactions for real-time claim adjudication and estimation requests, see the section addressing Real-Time Transaction Capability.

Real-Time Adjudication – allows providers to submit an electronic claim[1] that is adjudicated in real-time and receive a Health Care Claim Payment/Advice (835) response at the point of service. This capability allows providers to accurately identify and collect amounts that are the member’s responsibility based on finalized claim adjudication results.

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

Real-Time Estimation – allows providers to submit an electronic claim[1] for a proposed service and receive a Health Care Claim Payment/Advice (835) response in real-time. The response estimates the amount that will be the member's responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.

- Real-Time Electronic Claim[1] Submission Limitations

  The following are limitations of the real-time electronic claim[1] process:

  - The real-time claim adjudication and estimation submission process is limited to a single claim (1 Loop 2300 – Claim Information) within an Interchange (ISA-IEA). Transmissions with more than a single claim will receive a rejected Implementation Acknowledgment For Health Care Insurance (999).
    - Only initial claims can be submitted; not replacement, void, etc.
    - Claims for FEP (Federal Employee Program) and Out-of-State Blue Cross Blue Shield may be submitted in real-time; however they will be moved to batch processing.
    - Claims submitted with the PWK Segment indicating an attachment is being sent may be submitted in real-time, however they will be moved to batch processing.

- Real-time General Requirements and Best Practices

  Trading Partners must account for Providers submitting both real-time and batch claims.

  Highmark recommends that the Trading Partner create two processes that will allow Providers to submit claims through their standard batch method of submission or through their real-time method of submission.

  NOTE: Estimates will not be accepted in batch mode, only real-time mode.

  Trading Partners must ensure that claims successfully submitted through their real-time process are not included in a batch process submission, resulting in duplicate claims sent to 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.

7.2 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 benefit plans, including Indemnity, Preferred Provider Organization (PPO), Point of Service (POS), Comprehensive Major Medical (CMM), Medicare Advantage, and Medicare Supplemental. Accurate reporting of Highmark’s NAIC code 54771 along with associated prefixes and suffixes is critical for claims submitted to Highmark EDI.

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. BlueCard also applies in certain situations for patients with coverage from other Pennsylvania Plans, as detailed in the subsection below. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha prefix. Also, Highmark must be listed as the payer by submitting Highmark’s NAIC code of 54771 with the appropriate W or C suffix (see GS03 note) in the GS03 Application Receiver’s Code and the loop 2010BB NM109 Payer ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with another Plan. If the alpha prefix portion of the Member ID is missing, the claim will be processed as if the patient

were a local Highmark 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 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.

Transaction Limitations

Real-time Health Care Claim: Institutional (837I) submissions are limited to 50 lines per claim.

Real-Time Claim Adjudication and Estimation

Highmark real-time claim adjudication and claim estimation processes leverage the electronic claim[1] transaction. The real-time electronic claim[1] applies the same business rules and edits as the batch electronic claim[1], with the exception of items listed below. Highmark requires that claims submitted for estimation be differentiated from claims submitted for adjudication within the SOAP of the HTTPS transmission protocol. For information on SOAP, connectivity and the related transactions for real-time claim adjudication and estimation requests, see Section 4.4 of the Communication/Connectivity Companion.

Real-Time Adjudication – allows providers to submit an electronic claim[1] that is adjudicated in real-time and receive a Health Care Claim Payment/Advice (835) response at the point of service. This capability allows providers to accurately identify and collect amounts that are the member's responsibility based on finalized claim adjudication results.

Real-Time Estimation – allows providers to submit an electronic claim[1] for a proposed service and receive a Health Care Claim Payment/Advice (835) response in real-time. The response estimates the amount that will be the member's responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.

- Real-Time Electronic Claim[1] Submission Limitations

  The following are limitations of the real-time electronic claim[1] process:

  - The real-time claim adjudication and estimation submission process is limited to a single claim (1 Loop 2300 – Claim Information) within an Interchange (ISA-IEA).

Transmissions with more than a single claim will receive a rejected Implementation Acknowledgment for Health Care Insurance (999).

- Only initial claims can be submitted; not replacement, void, etc.
- Claims for FEP (Federal Employee Program) and Out-of-State Blue Cross Blue Shield may be submitted in real-time; however they will be moved to batch processing.
- Claims submitted with the PWK Segment indicating an attachment is being sent may be submitted in real-time, however they will be moved to batch processing.
- Real-time Health Care Claim: Institutional (837I) submissions are limited to 50 lines per claim.
- Real-time General Requirements and Best Practices

  Trading Partners must account for Providers submitting both real-time and batch claims.

  Highmark recommends that the Trading Partner create two processes that will allow Providers to submit claims through their standard batch method of submission or through their real-time method of submission.

  NOTE: Estimates will not be accepted in batch mode, only real-time mode.

  Trading Partners must ensure that claims successfully submitted through their real-time process are not included in a batch process submission, resulting in duplicate claims sent to 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[1], 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[1] transaction. See section 4.4 Communication Protocol Specifications information on retrieving the batch Health Care Claim Acknowledgment (277CA).

Real-Time Health Care Claim Acknowledgment (277CA)

Highmark implemented real-time capability for claim adjudication and claim estimation. The Health Care Claim Acknowledgment (277CA) is used in real-time claim adjudication and estimation processes in specific situations to return a reply of “accepted” or “not accepted” for claim adjudication or estimation requests submitted via the electronic claims[1] transactions. Acceptance at this level is based on electronic claims[1] Implementation Guides and Highmark’s front-end edits. The Health Care Claim Acknowledgment (277CA) will be used to provide status on:

- Claim adjudication and electronic claim[1] estimation requests that are rejected as a result of data validation and business data editing (i.e. front-end edits).

- Claim adjudication and electronic claim[1] estimation requests accepted through data validation and business editing, but could not be finalized through adjudication/estimation and reported on a real- time Health Care Claim Payment/Advice (835) response.

RT Claim Adjudication

For claims accepted into the system for adjudication, but not finalized through the real-time Health Care Claim Payment/Advice (835):

- These claims will continue processing in a batch mode and be reported in a daily or weekly batch ‘payment cycle Health Care

Claim Payment/Advice (835)' when adjudication has been completed.

- The Health Care Claim Acknowledgment (277CA) claim status reported for these claims will be:

  Category Code – A2: Acknowledgment/Acceptance into adjudication system.

  Status Code – 685: Claim could not complete adjudication in real-time. Claim will continue processing in a batch mode. Do not resubmit.

Real-Time Claim Estimation

For estimations accepted into the system, but not finalized through the real-time Health Care Claim Payment/Advice (835):

- The estimation will NOT continue estimation processing in a batch mode or be reported in a subsequent batch 835.
- The claim status reported for these estimations will be:

  Category Code – A2: Acknowledgment/Acceptance into adjudication system.

  Status Code – 687: Claim estimation cannot be completed in real- time. Do not resubmit.

For information on connectivity and the related transactions for real- time claim adjudication and estimation, see Section 7 of the Communications/Connectivity Companion Guide.

RT General Requirements and Best Practices

Trading Partners must process the acknowledgement response returned from Highmark.

Best Practice: Trading Partners are recommended to have a user-friendly messaging screen that can display relevant information and status codes interpreted from the Health Care Claim Acknowledgment (277CA) and other acknowledgment responses, such as the SOAP Fault, TA1 and Implementation Acknowledgment For Health Care Insurance (999). This will enable office staff to understand and correct the relevant transaction information for resubmission, if applicable

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 transaction 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 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

Member Facility Institutional Claims

The Reversal and Correction methodology will be utilized to recoup immediate refunds for overpayments identified by the provider or by Highmark. The change in payment details is reflected by a reversal claim (CLP02 = 22) and a corrected claim (CLP02 = 1, 2, 3, or 4). The payment amount of the check/EFT will be reduced by the overpayment amount, after any outstanding provider offsets are applied from previous checks/EFTs.

If Highmark is unable to recoup all or a portion of the refund money from the current check/EFT, the remaining refund amount to be offset on a future check will be shown as a negative amount in the Provider Adjustment PLB segment of the Health Care Claim Payment/Advice (835) using the Provider Adjustment Reason code of FB – Forward Balance. The negative PLB dollars allow

the Health Care Claim Payment/Advice (835) payment to balance and essentially delay or move the refund balance forward to a future Health Care Claim Payment/Advice (835), when money is available to be offset from a check/EFT.

When the refund dollars are eventually offset in a subsequent check/ EFT, the money is only reflected in the Health Care Claim Payment/Advice (835) PLB Segment with the dollar amount being offset from that specific check/EFT. Note that the reversal and correction claim detail is not repeated in 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

Professional and Non-member 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 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 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 Payment (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~

Real-Time Health Care Claim Payment/Advice (835) Response

Highmark implemented real-time capability for claim adjudication and claim estimation. A real-time Health Care Claim Payment/Advice (835) will be used as the response to a real-time claim adjudication or electronic claim[1] estimation request. The real-time Health Care Claim Payment/Advice (835) response will contain the finalized results from successful claim adjudication or estimation requests. The real-time Health Care Claim Payment/Advice (835) response will be based on the ASC X12 Health Care Claim Payment/Advice (835) Transaction adopted under the HIPAA Administrative Simplification Electronic Transaction rule.

For information on connectivity and the related transactions for real-time claim adjudication and estimation, see Section 7 of the Communication/Connectivity Companion Guide.

Real-Time Response for Claim Adjudication

The real-time Health Care Claim Payment/Advice (835) response for real-time claim adjudication will not contain the actual payment/check information. Actual payment for real-time adjudicated claims will continue to be generated through daily and weekly payment cycles and be subsequently reported in the respective batch payment cycles or payment Health Care Claim Payment/Advice (835).

The following table highlights some of the Health Care Claim Payment/Advice (835) data elements that have specific relevance to the reporting of real-time adjudicated claims within the Health Care Claim Payment/Advice (835).

835 Data	835 Element	Comments
835 Handling Code	BPR01=H	Required element – Indicates Notification only". No actual payment is being made.
835 "Payment" Amount	BPR02= CLP04	Required elements – The Real-Time Health Care Claim Payment/Advice (835) "payment" amount (BPR02) will equal the claim "paid" amount (CLP04) since this will be a single claim Health Care Claim Payment/Advice (835).
Payment Method	BPR04= NON	Required element – Indicates

835 Data	835 Element	Comments
		"Non- Payment Data". This is an informational only Health Care Claim Payment/Advice (835) and no dollars are being moved
Check/EFT/ Trace Number	TRN02	Required element –A non-payment Trace Number will be created. This number has no real value in the Real-Time Health Care Claim Payment/Advice (835) Response environment.
Claim Data	Loops 2000, 2100 & 2110	The claims data will be reported as adjudicated with appropriate liabilities and provider 'payment' amount

Real-Time Health Care Claim Payment/Advice (835) Response for Claim Estimation

The real-time Health Care Claim Payment/Advice (835) response for a real-time claim estimation request will follow the guidelines defined in the ASC X12 Health Care Claim Payment/Advice (835) Guide, Section 1.10.2.7 for "Predetermination of Benefits".

The following table highlights some of the data elements that have specific relevance to the reporting of real-time estimation responses within the Health Care Claim Payment/Advice (835).

NOTE: Claim estimation will not result in claim payment. A claim will need to be submitted for adjudication after the actual services are rendered.

835 Data	835 Element/Segment	Comments
835 Handling Code	BPR01=H	Required element – Indicates Notification only". No actual payment is being made.
Check Payment	BPR02=0	Required element – estimation Amount 835 Check Payment Amount will equal 0.
Payment Amount	BPR04= NON	Required element – Indicates "Non- Payment Data". This is an

835 Data	835 Element/Segment	Comments
		informational only Health Care Claim Payment/Advice (835) and no dollars are being moved
Check/EFT/ Trace Number	TRN02	Required element –A non-payment Trace Number will be created. This number has no real value in the Real-Time Health Care Claim Payment/Advice (835) Response environment.
Claim Status	CLP02	Required element – Code 25: Predetermination Pricing Only – No Payment.
Claim Paid	CLP04	Required element – The Claim Paid amount will equal 0
Service Paid	SVC03	Required element – The Service Paid amount will equal 0.
Claim/Service Adjustment	CAS	CAS Segment will report all member and provider contractual liabilities. The estimated provider paid amount will be assigned Group and Reason Code OA101. This CAS Segment adjustment will bring the claim paid amount and service paid amount to 0. CAS*OA*101*$$$$ CAS is reported at the applicable Line or Claim level.

Real-Time General Requirements and Best Practices

Trading Partners must have the ability to parse and interpret the information on the Health Care Claim Payment/Advice (835) response.

- Best Practice: Trading Partners are recommended to separate the information that will be displayed to the member from the

information displayed to the provider. It is recommended that only member liability data from the real-time Health Care Claim Payment/Advice (835) claim/estimate response be presented on the screen or printed document shown to the member. Some of the provider contractual liabilities and other Health Care Claim Payment/Advice (835) data reporting on the real-time Health Care Claim Payment/Advice (835) may not be useful to the member and may cause confusion.

- Best Practice: Trading Partners are strongly recommended to have a user-friendly messaging screen that can be displayed, printed, and handed to a member to show adjudication or estimation results from the real-time Health Care Claim Payment/Advice (835). Highmark recommends the 'Member Liability Statement' format and data presented be modeled after the statements developed by Highmark. Example 'Real-Time Member Liability Statements' for both adjudicated claims and estimations are located in the Resources section under EDI Companion Guides at the following site:

- https://edi.highmark.com/edi/resources/guides/index.shtml

- Best Practice: Trading Partners are recommended to have the dynamic statement printed on the Member Liability Statement that reads "Administered By Highmark" Note: All necessary disclaimers for the transaction will be included as one of the Remittance Advice Remark Codes passed in the real-time Health Care Claim Payment/Advice (835).

Full Accounts Receivable posting should occur from the actual "Payment Health Care Claim Payment/Advice (835)" generated from the batch payment/check cycle.

- Best Practice: Providers should post any dollar amounts received from the member as a result of the member liability reported in the real-time 835, but not post the payment or contractual obligation amounts until the batch or payment Health Care Claim Payment/Advice (835) is received.

Full Accounts Receivable posting should not be performed based on an estimation response.

- Best Practice: If services are rendered based on an estimate, the provider may post dollars received from the member based on the reported member liability from the proposed services, but not post the contractual obligation amounts until the services are rendered, the claim is submitted, adjudicated and finalized. The provider's

systems should have the capability to record member liability collected, if the feature does not already exist with the system.

Trading Partners must process and display on their screens and printed documents appropriate Remittance Advice Remark Codes that are reported in the real-time Health Care Claim Payment/Advice (835) response. Several new real-time related Remittance Advice Remark Codes have been created for standard messaging.

Trading Partner systems must be able to identify and react accordingly to both a “Real-Time Health Care Claim Payment/Advice (835)” transaction and a batch cycle “Payment Health Care Claim Payment/Advice (835)” transaction and to process both real-time and batch claims in a single system.

7.5 005010X212 Health Care Claim Status Request and Response (276/277)

The 276 transaction is used to request the status of a health care claim(s) and the 277 transaction is used to respond with information regarding the specified claim(s). The August 2006 ASC X12 Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage, and requirements.

Highmark NAIC Code 54771 includes Indemnity, Comprehensive Major Medical (CMM), Major Medical (MM), Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (POS), Medicare Supplemental, Federal Employees Health Benefit Plan, and Gateway Vision, and Independence Blue Cross/Highmark joint products.

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

An operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept 276 request transactions and return 277 response transactions when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the patient’s Member ID must be submitted with its alpha prefix and Highmark must be listed as the payer by submitting Highmark’s NAIC code of 54771 in the GS03 Application Receiver’s Code and the loop 2100A NM109 Payer ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate with another Plan. Responses from another Plan may vary in level of detail or code usage from a Highmark response. This arrangement also applies in certain situations for patients with coverage from other Pennsylvania Plans, as detailed in the following subsections.

- **Independence Administrators Out-of-Area**

  Providers outside the Independence Blue Cross (IBC) 5 county service area that are not Personal Choice Network Providers should submit requests with Highmark listed as the Payer/Information Source. Follow instructions in this Reference Guide for 276 and 277 transactions. Highmark will use the Member ID alpha prefix to identify the need to coordinate with Independence Administrators. The IBC service area includes the following counties: Philadelphia, Bucks, Chester, Delaware, and Montgomery.

- **Keystone Health Plan Central (KHP Central) Out-of-Area Only**

  Providers outside the KHP Central Service Area should submit requests with Highmark listed as the Payer/Information Source. Submit requests with **Highmark** listed as the Payer/Information Source. Follow instructions in this Reference Guide for 276 and 277 transactions. Highmark will use the Member ID alpha prefix to identify the need to coordinate with KHP Central.

  KHP Central Service Area includes the following counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York

Requests per Transaction Mode

Claim status requests will be processed in real-time mode only. Claim status responses will only include information available on the payer's adjudication system. Claim data which has been purged from the system will not be available on the response. The Claim Status process for Highmark is limited to one Information Source, Information Receiver, Provider, and Patient (Subscriber or Dependent) per ST - SE transaction. If multiple requests are sent, the transaction will be rejected.

Dental Services

All status requests containing a CDT dental procedure code must be submitted directly to Highmark's dental associate, United Concordia Companies, Inc. (UCCI). Any claim status requests for oral surgery services reported with a CPT medical procedure code must be requested to either Highmark or UCCI according to which payer is responsible for the patient's oral surgery coverage.

Claim Status Search Criteria

Highmark will use the following 3 data elements to begin the initial claim search:

Provider NPI	2100C
Member ID	2100D
Service Date(s)	2200D/E or 2210D/E

If the Highmark assigned claim number is also submitted (2200D/E REF), the initial search will be limited to a claim with an exact match to that claim number and the 3 initial claim search data elements. If an exact match is not found, a second claim search will be performed using the 3 initial claim search data elements.

Highmark will use the following elements and data content to narrow down the matching criteria after searching for claims based on the 3 initial claim search data elements:

Patient Date of Birth and Gender	2000D/E
Patient Last and First Name	2100D/E
Patient Control Number	2200D/E
Claim Charge Amount	2200D/E
Line Item Control Number	2210D/E

Maximum Claim Responses per Subscriber/Patient/ Dependent

If multiple claims are found for one status request, Highmark will respond with a maximum of 30 claims. If the 30 claim maximum is met, the requestor should change the data in the 276 request and submit a new request if the claims returned do not answer the initial status request.

Corrected Subscriber and Dependent Level

Data should always be sent at the appropriate Subscriber or Dependent level, based on the patient's relationship to the Insured. If the data is at the incorrect level, but Highmark is able to identify the patient, a 277 response will be returned at the appropriate, corrected level (subscriber or dependent) based on the enrollment information on file at Highmark.

Claim Splits

Claims that were split during processing will be reported as multiple claims on the 277 Claim Status Response when a Payer Claim Control Number (2200D/E REF) was not submitted on the 276 Request. When a Payer Claim Control Number is reported for a claim that was subsequently split during processing, the 277 Response will only return the portion of the claim specific to the reported Payer Claim Control Number.

Claim vs. Line Level Status

The 276 Health Care Claim Status Request can be used to request a status at a claim level or for specific service lines. The 277 Health Care Claim Status Response will contain information for both pending and finalized claims.

Service line information and status will be returned for both professional and institutional claims. All claim service lines will be returned on a 277 Response to a 276 Request that indicated specific service lines.

Only Claim level information and status will be returned on a 277 Response where a requested claim cannot be found or a system availability issue occurs.

7.6 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

The 270 transaction is used to request the health care eligibility for a subscriber or dependent. The 271 transaction is used to respond to that request. The May 2006 ASC X12 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.

Patient with Coverage from another Blue Cross Blue Shield Plan

An operating arrangement among Plans that are licensees of the BlueCross Blue Shield Association allows Highmark to accept 270 request transactions and return 271 response transactions when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the patient's Member ID must be submitted with its alpha prefix and Highmark must be listed as the payer by submitting Highmark's NAIC code of 54771 in the GS03 Application Receiver's Code and the loop 2100A NM109 Information Source ID. Highmark will use the Member ID alpha prefix to identify the need to coordinate with another Plan. Responses from another Plan may vary in level of detail or code usage from a Highmark response. This arrangement also applies in certain situations for patients with coverage from other Pennsylvania Plans, as detailed in the following subsections.

- **Independence Administrators**

  Out-of-Area Providers outside the Independence Blue Cross (IBC) 5 county service area that are not Personal Choice Network Providers should submit requests with Highmark listed as the Payer/Information Source. Follow instructions in this Reference Guide for 270 and 271 transactions. Highmark will use the Member ID alpha prefix to identify the need to coordinate with Independence Administrators. The IBC service

area includes the following counties: Philadelphia, Bucks, Chester, Delaware, and Montgomery

- **Keystone Health Plan East (KHP East)**

  Out-of-Area Providers outside the Independence Blue Cross (IBC) 5 county service area should submit requests with Highmark listed as the Payer/ Information Source. Follow instructions in this Reference Guide for 270 and 271 transactions.

Requests Per Transaction Mode

The Eligibility Inquiry requests will be processed in real-time mode only. The inquiry process for the payers in this Reference Guide is limited to one Information Source, and Information Receiver per ST - SE transaction. If multiple requests are sent, the transaction will be rejected.

Patient Search Criteria

In addition to the Required Primary and Required Alternate Search options mandated by the 270/271 implementation guide, Highmark will search for the patient if only the following combinations of data elements are received on the 270 request:

- Subscriber ID, Patient First Name, and Patient Date of Birth
- Subscriber ID and Patient Date of Birth

7.7 005010X217 Health Care Services Review- Request for Review and Response (278)

The Health Care Services Review (278) request transaction is utilized by providers and facilities to request reviews for specialty care and admissions. The Health Care Services Review (278) response is utilized by Utilization Management Organizations (UMOs) to response with results for reviews for specialty care and admissions. The May 2006 ASC X12 005010X217 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 and receiving Health Care Services Review (278) requests and responses 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 278 transactions submitted to Highmark EDI.

Patients with Coverage from an Out-of-State Blue Cross Blue Shield Plan

An operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept 278 request transactions and return 278 response transactions when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the patient's Member ID must be submitted with its alpha/numeric prefix and Highmark must be listed as the payer by submitting Highmark's NAIC code of 54771 in the GS03 Application Receiver's Code and the loop 2010A NM109 UMO ID. Highmark will use the Member ID alpha/numeric prefix to identify the need to coordinate with another Plan. Responses from another Plan may vary in level of detail or code usage from a Highmark response.

Requests Per Transaction Mode

The Authorization Request/Response requests will be processed in real-time mode only. The process for the payers in this Reference Guide is limited to one Utilization Management Organization (Information Source) and one Requester (Information Receiver) per ST – SE transaction. If multiple requests are sent, the transaction will be rejected.

Patients with Highmark Benefit Plans and Federal Employees Health Benefit Plans

Authorization Requests that pass Business Requirements defined below as well as Patient, Provider and Clinical data checks will be processed. A 278 Pended Response will be returned along with the Payer assigned Authorization Number in Loop 2000E and 2000F (if applicable) REF02 (REF01 Qualifier = NT).

	Business Requirement	Error 278 Response
1	Only Initial Requests will be processed. Loop 2000E UM02 = I Any other value Revision, Extensions or Cancellations will generate an error on the 278 Response	Loop 2000E AAA03 = 33 MSG01 = ONLY INITIAL REQUESTS ARE SUPPORTED. IN ORDER TO COMPLETE YOUR REQUEST, PLEASE CONTACT THE PATIENT'S INSURANCE PLAN. FOR LOCAL PATIENTS CONTACT MEDICAL MANAGEMENT & POLICY AT 1-800-547-3627. FOR OUT OF AREA PATIENTS CALL THE NUMBER ON THE BACK OF THE CARD.
2	At least 1 Diagnosis Code must be present. Loop 2000E HI01-2 All Submitted Diagnosis Codes must be Valid	Missing Diagnosis Code Loop 2000E AAA03 = 33 Invalid Diagnosis Code Loop 2000E

		AAA03 = AF
3	Requests must contain a Unique Service Provider or Facility where Loop 2010EA and/or 2010F NM101 = SJ or FA. Multiple different Service Provider or Facility where Loop 2010EA and/or 2010F NM101 = SJ or FA. will not be processed.	Loop 2000E and 2000F if received on the 278 Request HCR01 = A3 HCR03 = 0C MSG01 = ONLY ONE SERVICE PROVIDER IS SUPPORTED. IN ORDER TO COMPLETE YOUR REQUEST, PLEASE CONTACT THE PATIENT'S INSURANCE PLAN. FOR LOCAL PATIENTS CONTACT MEDICAL MANAGEMENT & POLICY AT 1-800-547-3627. FOR OUT OF AREA PATIENTS CALL THE NUMBER ON THE BACK OF THE CARD. Loop 2010EA or 2010FA AAA03 = 41
4	Authorization Type must be consistent in 2000E and 2000F 4 Possible Authorization Types are derived using the Service Type (UM03) and Place of Service (UM04-2) in Loop 2000E and 2000F • Behavioral-Inpatient • Behavioral-Outpatient • Medical-Inpatient • Medical-Outpatient	Loop 2000E and 2000F AAA03 = 33 MSG01 = SERVICE TYPE CLASSIFICATION INCONSISTENT. IN ORDER TO COMPLETE YOUR REQUEST, PLEASE CONTACT THE PATIENT'S INSURANCE PLAN. FOR LOCAL PATIENTS CONTACT MEDICAL MANAGEMENT & POLICY AT 1-800-547-3627. FOR OUT OF AREA PATIENTS CALL THE NUMBER ON THE BACK OF THE CARD.

7.8 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. In real-time mode, a rejected Implementation Acknowledgment for Health Care Insurance (999) is returned only when the applicable real-time response transaction cannot be returned due to rejections at this level. 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^          ^33^54771          ^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
IEA^1^035738627
```

7.9 Additional Information to Support a Health Care Services Review (275)

The Additional Information to Support a Health Care Services Review (275) request transaction is utilized by providers and facilities to send additional information about a services review/prior authorization request. This implementation guide is designed to assist those who are responding to a **solicited** request for additional supporting information for a service review (278) using the 275 format. The February 2008 ASC X12 005010X211 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 and receiving Additional Information to Support a Health Care Services Review (275) request and responses 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 EDI.

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

Outgoing Interchange Acknowledgment TA1 Segment

Highmark returns a TA1 Interchange Acknowledgment segment in both batch and real-time modes 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. In real-time mode, a rejected Implementation Acknowledgment for Health Care Insurance (999) is returned only when the applicable real-time response transaction cannot be returned due to rejections at this level. 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[1] 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 (ST-SE) that correspond to the submitted 837 Functional Group and transactions (ST-SE).

The Health Care Claim Acknowledgement (277CA) is used within the real-time claim process for certain situations when a real-time Health

Care Claim Payment/Advice (835) response could not be generated. Acceptance at this level is based on the electronic claim[1] Implementation Guides and front-end edits, and will apply to individual claims within an electronic claim[1] transaction. For those claims not accepted, the Health Care Claim Acknowledgement (277CA) will detail additional actions required of the submitter in order to correct and resubmit those claims. For details on this transaction, please refer to the Health Care Claim Acknowledgement (277CA) in Sections 7.3 and 10 of this Companion Guide.

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

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 Acme customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Acme.

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 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 table 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
005010X212 Health Care Claim Status Request and Response*
005010X279A1 Health Care Eligibility Benefit Inquiry and Response*
005010X217 Health Care Services Review-Request for Review and Response*
005010X231A1 Implementation Acknowledgment for Health Care Insurance

Highmark supports the transactions marked with an '*' in real-time only. All other listed transactions are supported in both batch and real-time.

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. For real-time claim adjudication or estimation, add a prefix of "R" to the Trading Partner number. For more information on how to distinguish the type of real-time 837, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' located in the 'Resources'' section under EDI Companion Guides at the following website: https://edi.highmark.com/edi/resources/guides/index.shtml
	GS03	Application Receiver's Code	54771 54771V 15460	Highmark Highmark Vision (includes Gateway Health Plan Vision) Highmark Senior Health Company
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

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Receiver Primary Identifier	54771 15460	Identifies Highmark as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. Highmark Senior Health Company
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.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha 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
	NM109	Payer Identifier	54771 54771V 15460	Highmark Highmark Vision (includes Gateway Health Plan Vision) Highmark Senior Health Company
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 **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 Highmark's Provider Resource website at:: https://content.highmarkprc.com/Files/Region/PA/Forms/Claim_Suppl_Info_Cover_Sheet.pdf **4.** Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

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. **mail to** Highmark Attachments, PO Box 890176, Camp Hill PA 17089-0176 **fax to** 888-910-8797
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	Health Care Diagnosis Code		ICD-10-CM Diagnosis Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Diagnosis Codes will continue to be accepted for dates of service prior to October 1, 2015
2300	HI	Anesthesia Related procedure		Send the procedure code for the surgery or other service related to the anesthesia, if known. If the only applicable code is a Not Otherwise Classified code, send a description of the service in the Procedure Code Description, element SV101-7.
2310B	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.

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	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.
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.
2330B	N4	Other Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Other Payer's city, state and zip, send the Billing Provider address information as the default.
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**
	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	AA AD GC QK QX QY 47	For anesthesia services where the billing provider is not a Certified Registered Nurse Anesthetist (CRNA), Highmark requires submission of one of the listed anesthesia certification modifiers
			QZ	If the billing provider is not participating and is not in Pennsylvania, code value QZ is also valid.
			QX QZ	For anesthesia services where the billing provider is a CRNA, Highmark requires submission of one of the listed anesthesia certification modifiers.
			AA AD GC QK QY 47	If the billing provider is not participating and not in Pennsylvania, code values are also valid.
	SV103	Unit / Basis for Measurement Code		Anesthesia CPT codes (00100-01999) must be reported with minutes, except code 01996 which is reported with units indicating the number of days managing continuous drug administration. Moderate (Conscious) Sedation Codes 99143 - 99145 and 99148 - 99150, and anesthesia modifying unit procedure codes 99100, 99116, 99135, 99140 are reported with UN, Units and not MJ, Minutes.

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 Highmark's Provider Resource website at: https://www.highmark.com/health/pdfs/forms/Claim_Suppl_Info_Cover_Sheet.pdf **4.** Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

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. **mail to** Highmark Attachments, PO Box 890176, Camp Hill PA 17089-0176 **fax to** 888-910-8797
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. For real-time claim adjudication or estimation, add a prefix of "R" to the Trading Partner number. For more information on how to distinguish the type of real-time 837, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' located in the 'Resources'' section under EDI Companion Guides at the following website: https://edi.highmark.com/edi/resources/guides/index.shtml
	GS03	Application Receiver's Code	54771C 54771W 15460	Facility in Highmark's Central Region (Plan Code 378). Facility in the 29 counties of Highmark's Western Region (Plan Code 363). Highmark Senior Health Company
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
	NM109	Receiver Primary Identifier	54771 15460	Identifies Highmark as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. Highmark Senior Health Company

005010X223A2 Health Care Claim: Institutional				
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 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.

005010X223A2 Health Care Claim: Institutional				
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
	NM109	Payer Identifier	54771C 54771W 15460	Facility in Highmark's Central Region (Plan Code 378). Facility in the 29 counties of Highmark's Western Region (Plan Code 363). Highmark Senior Health Company
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 Highmark's Provider Resource website at:: https://content.highmarkprc.com/Files/Region/PA/Forms/Claim_Suppl_Info_Cover_Sheet.pdf **4.** Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

005010X223A2 Health Care Claim: Institutional				
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. **mail to** Highmark Attachments, PO Box 890176, Camp Hill PA 17089-0176 **fax to** 888-910-8797
2300	REF	Payer Claim Control Number		
	REF02	Payer Claim Control Number		Highmark's claim number of the previous claim is needed when this claim is a replacement, void or late charge (CLM05-3 value of 5, 7, or 8) related to that previously adjudicated claim.
2300	K3	File Information		Present on Admission (POA) codes are not reported in the K3. Claims with POA codes in the K3 will not be accepted for processing. POA codes are reported in the appropriate HI segment along with the appropriate diagnosis code.
2300	HI	Principal Diagnosis		ICD-10-CM Diagnosis Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Diagnosis Codes will continue to be accepted for dates of service prior to October 1, 2015
2300	HI	Admitting Diagnosis		ICD-10-CM Diagnosis Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Diagnosis Codes will continue to be accepted for dates of service prior to October 1, 2015
2300	HI	Patient's Reason for Visit		ICD-10-CM Diagnosis Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Diagnosis Codes will continue to be accepted for dates of service prior to October 1, 2015

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	HI	Other Diagnosis		ICD-10-CM Diagnosis Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Diagnosis Codes will continue to be accepted for dates of service prior to October 1, 2015
2300	HI	Principal Procedure Information		ICD-10-PCS Procedure Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Procedure Codes will continue to be accepted for dates of service prior to October 1, 2015.
2300	HI	Other Procedure Information		ICD-10-PCS Procedure Codes for dates of service on or after October 1, 2015 will be accepted as of October 1, 2015. ICD-9 Procedure Codes will continue to be accepted for dates of service prior to October 1, 2015.
	HI01-1	Code List Qualifier Code		Until further notification from Highmark, Advanced Billing Concepts (ABC) codes will not be accepted.
2300	HI	Occurrence Information		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.
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.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.
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.

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 Highmark's Provider Resource website at: https://www.highmark.com/health/pdfs/forms/Claim_Suppl_Info_Cover_Sheet.pdf **4.** Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

005010X223A2 Health Care Claim: Institutional				
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. **mail to** Highmark Attachments, PO Box 890176, Camp Hill PA 17089-0176 **fax to** 888-910-8797

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	 54771 15460	This will match the payer id in the GS03 of the claim transaction Highmark Highmark Senior Health Company
	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	 54771 15460	This will match the payer id in the GS03 of the claim transaction Highmark Highmark Senior Health Solutions
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.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
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.
	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.
	STC01-2	Health Care Claim Status Code	685	Health Care Claim Status Code '685: Claim could not complete adjudication in Real- Time. Claim will continue processing in a batch mode. Do not resubmit.' will be used for real-time claims that are accepted into the system for adjudication, but not finalized through the real-time 835.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC01-2	Health Care Claim Status Code	687	Health Care Claim Status Code '687: Claim estimation cannot be completed in real- time. Do not resubmit' will be used for real-time estimations accepted into the system, but not finalized through the real-time 835.
2200D	DTP	Claim Level Service Date		
	DTP02	Date Time Period Format Qualifier	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.
2200D	REF	Payer Claim Control Number		This segment will only be returned in a real-time 277 Claim Acknowledgment when a real-time claim (837) was accepted for adjudication, but could not be finalized through the real-time 835. This segment will not be returned for RT estimations This segment will not be returned for claims acknowledged in batch mode
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		.
	DTP02	Date Time Period Format Qualifier	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	54771 15460	This will match the payer id in the GS03 of the claim transaction Highmark Highmark Senior Health Company
	GS03	Application Receiver's Code		This will always be the Highmark assigned Trading Partner Number for the entity receiving this transaction.
	BPR	Financial Information		
	BPR01	Transaction Handling Code	H	**RT Estimation and Adjudication use:** This value will always be used in the real-time Health Care Claim Payment/ Advice (835) response since no actual payment is being made.
	BPR02	Total Provider Payment Amount		**RT Adjudication use:** The real-time Health Care Claim Payment/ Advice (835) "payment" amount (BPR02) will equal the claim "payment" amount (CLP04) since this will be a single claim Health Care Claim Payment/ Advice (835). Actual payment for claims adjudicated in real-time will be reported in a batch or payment cycle 835.
	BPR04	Payment Method Code	NON	**RT Estimation and Adjudication use:** This value will always be used in the real-time Health Care Claim Payment/ Advice (835) response since no actual payment is being made or money moved.
	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		

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	N102	Payer Name	Highmark Health Care Account	**Health Care Spending Account use:** This Payer Name will be used to distinguish an Health Care Claim Payment/ Advice (835) that contain claim payments from members'' Health Care Spending Accounts. See Section 7.4 for more information.
1000A	REF	Additional Payer Identification		
	REF01	Reference Identification Qualifier	NF	This value will always be used.
	REF02	Additional Payer Identification	54771 15460	Highmark Highmark Senior Health Company
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.
	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.

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	CLP02	Claim Status Code	25	**RT Estimation use:** Highmark will always use this value for status on a real-time Estimation response.
	CLP04	Claim Payment Amount		**RT Adjudication use:** The real-time Health Care Claim Payment/ Advice (835) Claim 'Payment' Amount (CLP04) will equal the Provider 'Payment' Amount (BPR02) since this will be a single claim Health Care Claim Payment/ Advice (835). **RT Estimation use:** The Claim Payment Amount will always equal 0.
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. **RT Estimation use:** This Group Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the claim payment amount (CLP04) to 0.
	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.
			101	**RT Estimation use:** This Reason Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the claim paid amount to 0.
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		**RT Estimation use:** The Line Item Provider Payment Amount will always equal 0.
2110	CAS	Service Adjustment		
	CAS01	Claim Adjustment Group Code	OA	**RT Estimation use:** This Group Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the service paid amount to 0.
	CAS02	Claim Adjustment Reason Code	101	**RT Estimation use:** This Reason Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the service paid amount to 0.

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110	REF	Healthcare Policy Identification		Highmark will not be using the Healthcare Policy Identification Segment
	PLB	Provider Adjustment		
	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)

Refer to section 7.5 for Highmark Business Rules and Limitations

005010X212 Health Care Claim Status Request				
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, with a prefix R indicating a request for a real-time response. The submitted value must not include leading zero’s
	GS03	Application Receiver’s Code	54771 15460	To support Highmark’s routing process, all 276 transactions in a functional group must be for the same payer. Submit the NAIC number for the payer identified in loop 2100A of the 276 transaction.
2100A	NM1	Payer Name		
	NM103	Payer Name		Highmark will not use the payer name as part of their search criteria.
	NM108	Identification Code Qualifier	PI	

005010X212 Health Care Claim Status Request				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Payer Identifier	54771 15460	This must be the same number as identified in GS03. Highmark Senior Health Company
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the Highmark assigned Trading Partner Number. This must be the same Trading Partner number as identified in GS02. The submitted value must not include leading zero's.
2100C	NM1	Provider Name		This will always be the Billing Provider NPI.
	NM103	Provider Last or Organization Name		Highmark will not use the Provider Name when searching for claims.
	NM108	Identification Code Qualifier	XX	
	NM109	Provider Identifier		This will always be the Billing Provider NPI.
2100D	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Highmark will not use the subscriber name to search for claims unless the subscriber is the patient and the name is needed to narrow the search criteria.
	NM104	Subscriber First Name		Highmark will not use the subscriber name to search for claims unless the subscriber is the patient and the name is needed to narrow the search criteria.
	NM108	Identification Code Qualifier	MI	
	NM109	Subscriber Identifier		This is the identifier from the member's identification card (ID Card), including alpha 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.

005010X212 Health Care Claim Status Request				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2200D	REF	Payer Claim Control Number		
	REF02	Payer Claim Control Number		When the Payer Claim Control Number is provided, the payer will initially limit the search to an exact match of that control number. If an exact match is not found, a second search will be performed using other data submitted on the claim status request. See Section 7.5 Claim Status Search Criteria for more information.
2210D	SVC	Service Line Information		Highmark will not use the service line procedure code information reported in the SVC when searching for claims.
2000E	REF	Payer Claim Control Number		
	REF02	Payer Claim Control Number		When the Payer Claim Control Number is provided, the payer will initially limit the search to an exact match of that control number. If an exact match is not found, a second search will be performed using other data submitted on the claim status request. See Section 7.5 Claim Status Search Criteria for more information.
2210E	SVC	Service Line Information		Highmark will not use the service line procedure code information reported in the SVC when searching for claims.

005010X212 Health Care Claim Status Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	54771	Highmark
			15460	Highmark Senior Health Company
	GS03	Application Receiver's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating it is real-time response.
2100A	NM1	Payer Name		
	NM109	Payer Identifier	54771	Highmark
			15460	Highmark Senior Health Company

005010X212 Health Care Claim Status Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This will always be the Highmark assigned Trading Partner Number.
2200B	TRN	Information Receiver Trace Identifier		Highmark will not be returning status at the 2200B level.
2100C	NM1	Provider Name		
	NM108	Identification Code	XX	
	NM109	Provider Identifier		This will always be the Billing Provider NPI.
2200C	TRN	Provider of Service Trace Identifier		Highmark will not be returning status at the 2200C level.
2100D	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	MI	
	NM109	Subscriber Identifier		This will be the same member identification number that was submitted on the 276.
2200D	STC	Claim Level Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
2220D	SVC	Service Line Information		Highmark will return service line information when a finalized or pended claim is found.
2220D	STC	Service Line Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.

005010X212 Health Care Claim Status Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
2200E	STC	Claim Level Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
2220E	SVC	Service Line Information		Highmark will return service line information when a finalized or pended claim is found.
2220E	STC	Service Line Status Information		
	STC01-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC10-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.
	STC11-4	Code List Qualifier Code	RX	Highmark will not provide status using National Council for Prescription Drug Programs Reject/Payment Codes.

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

Refer to section 7.6 for Highmark Business Rules and Limitations

005010X279A1 Health Care Eligibility Benefit Inquiry				
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, with a prefix R indicating a request for a real-time response. The submitted value must not include leading zero's

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS03	Application Receiver's Code	54771 15460	Highmark Highmark Senior Health Company
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	Use this code to indicate that Highmark is a payer
	NM103	Information Source Last or Organization Name		The information in this element will not be captured and used in the processing
	NM108	Identification Code Qualifier	NI	Use this code to indicate the NAIC value is being sent in NM109
	NM109	Information Source Primary Identifier	54771 15460	Highmark Highmark Senior Health Company
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	2B 36 P5	Highmark business practices do not allow for eligibility inquiries from Third Party Administrators, Employers or Plan Sponsors.
	NM108	Identification Code Qualifier	XX PI	Provider Request Payer Request
2100B	REF	Information Receiver Additional Identification		The information in this segment will not be captured and used in the processing.
2100B	N3	Information Receiver Address		The information in this segment will not be captured and used in the processing.
2100B	N4	Information Receiver City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	NM1	Subscriber Name		
	NM109	Subscriber Primary Identifier		Enter the full Unique Member ID (Highmark) or Unique Subscriber ID (IBC) including the alpha prefix found on the patient's healthcare ID card.

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	6P F6 SY	If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help Highmark identify the patient. Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card.
2100C	N3	Subscriber Address		The information in this segment will not be captured and used in the processing.
2100C	N4	Subscriber City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	PRV	Provider Information		Highmark does not use the information in this segment except as noted below.
	PRV02	Reference Identification Qualifier	9K	This is the only qualifier Highmark processes.
2100C	HI	Subscriber Health Care Diagnosis Code		Highmark does not process eligibility responses as the Diagnosis level. Do not send.
2100C	DTP	Subscriber Date		
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		Highmark will accept this as a repeating element when applicable

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	EQ01	Service Type Code	35	Dental inquiries must be submitted to UCCI. Oral Surgery inquiries must be submitted to both Highmark for Medical coverage and UCCI for Dental coverage.
	EQ01	Service Type Code	11, 22, 34, 85, 87, A9, AA, AB, AC, AM, AO, BA, BE, BJ, BK, BL, BM, BP, BN, BR, BQ, BW, BX, B1, B2, B3, C1, DG, DS, FY, GF, GN, ON, PU, RN, RT, TC, TN	Highmark does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, Highmark will return eligibility for the following Service Type Codes: 1, 33, 35, 47, 48, 50, 51, 52, 86, 88, 98, 98 (MSG "Specialist"), BZ and MH.
	EQ02	Composite Medical Procedure Identifier		Highmark does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01
	EQ03	Coverage Level Code	FAM	Highmark does not process inquiries at the contract, or family, level. The 271 response will include only subscriber eligibility information
2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		Highmark does not consider the information in the III segment for processing.
2110C	DTP	Subscriber Eligibility/Benefit Date		

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing
2100D	REF	Dependent Additional Identification		
	REF01	Reference Identification Qualifier	6P F6 SY	If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help Highmark identify the patient. Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card.
2100D	N3	Dependent Address		The information in this segment will not be captured and used in the processing.
2100D	N4	Dependent City, State, Zip Code		The information in this segment will not be captured and used in the processing.
2100C	PRV	Provider Information		Highmark does not use the information in this segment except as noted below.
	PRV02	Reference Identification Qualifier	9K	This is the only qualifier Highmark processes.
2100C	HI	Dependent Health Care Diagnosis Code		Highmark does not process eligibility responses as the Diagnosis level. Do not send.
2100D	DTP	Dependent Date		

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing
2110D	EQ	Dependent Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		Highmark will accept this as a repeating element when applicable
	EQ01	Service Type Code	35	Dental inquiries must be submitted to UCCI. Oral Surgery inquiries must be submitted to both Highmark for Medical coverage and UCCI for Dental coverage.
	EQ01	Service Type Code	11, 22, 34, 85, 87, A9, AA, AB, AC, AM, AO, BA, BE, BJ, BK, BL, BM, BP, BN, BR, BQ, BW, BX, B1, B2, B3, C1, DG, DS, FY, GF, GN, ON, PU, RN, RT, TC, TN	Highmark does not process these Service Types. If they are received, they will be converted to Service Type '30' and receive an eligibility response based on that code
	EQ01	Service Type Code	30	When this value is received on a 270 request, in addition to the eligibility information for the required Service Type Codes, Highmark will return eligibility for the following Service Type Codes: 1, 33, 35, 47, 48, 50, 51, 52, 86, 88, 98, 98 (MSG "Specialist"), BZ and MH.
	EQ02	Composite Medical Procedure Identifier		Highmark does not process inquiries at the Procedure level and will provide an eligibility response as if a Service Type Code 30 were received in EQ01

005010X279A1 Health Care Eligibility Benefit Inquiry				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110D	III	Dependent Eligibility or Benefit Additional Inquiry Information		Highmark does not consider the information in the III segment for processing.
2110D	DTP	Dependent Eligibility/Benefit Date		
	DTP03	Date Time Period		Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date is up to 6 months in the future When DTP02 = RD8 and a date range is submitted in DTP03, Highmark will use the first date of the date range for processing

005010X279A1 Health Care Eligibility Benefit Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	54771 15460	This will match the payer id in the GS03 of the 270 transaction Highmark Highmark Senior Health Company
	GS03	Application Receiver's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a real-time response.
2100C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Highmark will accept up to 60 characters on the 270 Inquiry. However, only the first 35 characters will be returned on the 271 response

005010X279A1 Health Care Eligibility Benefit Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM104	Subscriber First Name		Highmark will accept up to 35 characters on the 270 Inquiry. However, only the first 25 characters will be returned on the 271 response
	NM108	Identification Code Qualifier	MI	This is the only qualifier Highmark will return on the 271 Response
	NM109	Subscriber Primary Identifier		If a contract ID that is not an Unique Member ID (UMI) or Unique Subscriber ID (USI) is submitted, Highmark will return the corrected UMI or USI in this element. The submitted ID will be returned in an REF segment with a Q4 qualifier.
2110C	EB	Subscriber Eligibility or Benefit Information		
	EB03	Eligibility or Benefit Information		Highmark will return this as a repeating element when applicable
2110C	DTP	Subscriber Eligibility/Benefit Date		
	DTP01	Date Time Qualifier	356 = eligibility begin/effective date 357 = eligibility end date 290 = re-verification/re-certification date	Highmark will return the Coordination of Benefits eligibility, effective, cancel or certification dates, if applicable
2110C	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".
2100D	NM1	Dependent Name		
	NM103	Dependent Last Name		Highmark will accept up to 60 characters on the 270 Inquiry. However, only the first 35 characters will be returned on the 271 response

005010X279A1 Health Care Eligibility Benefit Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM104	Dependent First Name		Highmark will accept up to 35 characters on the 270 Inquiry. However, only the first 25 characters will be returned on the 271 response
2110D	EB	Dependent Eligibility or Benefit Information		
	EB03	Eligibility or Benefit Information		Highmark will return this as a repeating element when applicable
2110D	DTP	Dependent Eligibility/Benefit Date		
	DTP01	Date Time Qualifier	356 = eligibility begin/effective date 357 = eligibility end date 290 = re-verification/re=certification date	Highmark will return the Coordination of Benefits eligibility, effective, cancel or certification dates, if applicable
2110D	MSG	Message Text		
	MSG01	Free Form Message Text		Benefit provisions that apply explicitly and only to Specialist Office Visits will be designated by narrative text in this segment of "SPECIALIST".

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

Refer to section 7.7 for Highmark Business Rules and Limitations

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		**T**he receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a request for a real-time response.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS03	Application Receiver's Code		To support Highmark's routing process, all authorization requests in a functional group should be for the same UMO. Submit the NAIC code for the UMO identified as the source of the decision/response in loop 2010A of the 278 transaction.
			54771	Highmark's
			15460	Highmark Senior Health Company
2010A	NM1	Utilization Management Organization (UMO) Name		
2010A	NM108	Identification Code Qualifier	PI	Payor Identifier
	NM109	Identification Code	54771 15460	Highmark NAIC Code Highmark Senior Health Company
2010B	N3	Requester Address		Due to Highmark's business practices, this information is needed to identify the requester's Practice, Physician, Supplier, or Institution office location. If Highmark is unable to identify the location, the default will be the main location on the Highmark system.
2010B	N4	Requester City, State, Zip Code		Due to Highmark's business practices, this information is needed to identify the requester's Practice, Physician, Supplier, or Institution office location. If Highmark is unable to identify the location, the default will be the main location on the Highmark system.
2010B	PER	Requester Contact Information		
	PER02	Name		Due to Highmark's business practices, this information is needed to process authorizations.
	PER03	Communication Number Qualifier	TE	Telephone

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PER04	Communication Number		Always include an area code with the telephone number.
2010C	NM1	Subscriber Name		
	NM103	Subscriber Last Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM104	Subscriber First Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM105	Subscriber Middle Name		Due to Highmark's business practices, this information is needed to process authorizations.
2010C	DMG	Subscriber Demographic Information		
2010C	DMG02	Subscriber Birth Date		The subscriber's birth date is needed when the subscriber is the patient.
2010D	NM1	Dependent Name		
	NM103	Dependent Last Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM104	Dependent First Name		Due to Highmark's business practices, this information is needed to process authorizations.
	NM105	Dependent Middle Name		Due to Highmark's business practices, this information is needed to process authorizations..
2010D	DMG	Dependent Demographic Information		
	DMG02	Dependent Birth Date		The dependent's birth date is needed when the dependent is the patient.
2000E	UM	Health Care Services Review Information		
	UM01	Request Category Code	AR	Use this value if this authorization is for inpatient place of service
	UM03	Service Type Code		Due to Highmark's business practices, this information is needed to process authorizations.
	UM04-1	Facility Type Code		Due to Highmark's business practices, this information is needed to process authorizations.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	UM04-2	Facility Code Qualifier	B	Enter code value for Place of Service code from the Centers for Medicare and Medicaid Services.
2000E	DTP	Admission Date		
	DTP01	Date Time Qualifier	435	Use this value if this authorization is for inpatient place of service
2000E	HI	Patient Diagnosis		Due to Highmark's business practices, this information is needed to process authorizations.
2000E	PWK			
	PWK02	Report Transmission Code	AA BM FX	Due to Highmark's business systems, these values are the only methods by which additional information can be received.
2010EA		Patient Event Provider Name		Due to Highmark's business practices, for Facility requests, one iteration of the Patient Event Provider Name Loop is needed to process authorization requests.
2010EA	N3	Patient Event Provider Address		Due to Highmark's business practices, this information is needed to process authorizations.
2010EA	N4	Patient Event Provider City, State, Zip Code		Due to Highmark's business practices, this information is needed to process authorizations.
2010EA	PER	Patient Event Provider Contact Information		
	PER02	Name		Please enter the name of the person Highmark should contact for additional information. If there is no specific person assigned to answer 278 Transaction inquiries, there must be a value in PER04 so Highmark can contact the provider.
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Always include an area code with the telephone number.
2000F	UM	Health Care Services Review Information		If different than the information located in the UM segment at the Patient Event Level, the following UM values are needed to process authorizations.
	UM03	Service Type Code		Due to Highmark's business practices, this information is needed to process authorizations.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	UM04-1	Facility Type Code		Due to Highmark's business practices, this information is needed to process authorizations..
	UM04-2	Facility Code Qualifier	B	Due to Highmark's business practices, this information is needed to process authorizations..
2000F	DTP	Service Date		Due to Highmark's business practices, this information is needed to process authorizations. Enter the proposed or actual date of the procedure.
2000F	SV1	Professional Service		
	SV101-1	Product/Service ID Qualifier	HC	For professional services, Highmark will only accept the codes from the Health Care Financing Administration Common Procedural Coding System external code list.
	SV202-1	Product/Service ID Qualifier	HC	For institutional services, Highmark will only accept the codes from the Health Care Financing Administration Common Procedural Coding System external code list.
2010F		Service Provider Name		Due to Highmark's business practices, for Professional requests, one iteration of the Service Provider Name Loop is needed to process authorization requests.
2010F	N3	Service Provider Address		Due to Highmark's business practices, this information is needed to process authorizations.
2010F	N4	Service Provider City, State, Zip Code		Due to Highmark's business practices, this information is needed to process authorizations.
2010F	PER	Service Provider Contact Information		
	PER02	Name		Please enter the name of the person Highmark should contact for additional information. If there is no specific person assigned to answer 278 Transaction inquiries, there must be a value in PER04 so Highmark can contact the provider.

005010X217 Health Care Services Review Request for Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Always include an area code with the telephone number.

005010X217 Health Care Services Review- Response				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	54771 15460	Highmark will send the NAIC code for the Utilization Management Organization (UMO) that is sending this response. Highmark = 54771 Highmark Senior Health Company
	GS03	Application Receiver's Code		The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix R indicating a real-time response.
	GS06	Group Control Number		Highmark will send a unique control number for each functional group.

005010X211 Additional Information to Support a Healthcare Services Review (275)

Refer to section 7.9 for Highmark Business Rules and Limitations

005010X211 Additional Information to Support a Healthcare Services Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		**T**he receiver's Highmark-assigned Trading Partner Number will be used.

005010X211 Additional Information to Support a Healthcare Services Review				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS03	Application Receiver's Code	54771	To support Highmark's routing process, all authorization requests in a functional group should be for the same UMO. Submit the NAIC code for the UMO identified as the source of the decision/response. Highmark's
	BGN			
	BGN01	Transaction Set Purpose Code	11	Use when submitting a solicited 275 as a request for additional information. *An unsolicited 275 is not supported at this time. If one is submitted it will not be rejected or processed. (value of 02)
1000B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	PR	
	NM102	Entity Type Qualifier	2	Non-Person
	NM103	Organization Name		HIGHMARK
	NM108	Identification Code Qualifier	PI	Payor Identifier
	NM109	Identification Code		54771
2000A	TRN	Attachment Control Number		
	TRN02	Reference Identification		This value should be the Payer Assigned Authorization number. NOTE: If this 275 solicited is in response to a 278 then the Payer Assigned Auth number would be found in Loop 2000E and 2000F (if applicable), REF02 (REF01 Qualifier = NT).

005010X231A1 Implementation Acknowledgment For Health Care Insurance (999)

Refer to section 7.8 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

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 March 2017 version to this October 2023 version of the Provider Companion Guide.

Page	Section	Description
	Multiple	Replace eDelivery with Secure Transport throughout the document.
	Multiple	Replace ftp.highmark.com with mft.hmhs.com.
	Multiple	Replace references to FTP to reference SFTP as protocol.
	Multiple	Update references to URL highmark.com/edi.
	7.3 & 8.2	Outline changes related to 277CA bundling.
	Multiple	Added 275 transaction.

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted