# Provider EDI Reference Guide

***Highmark EDI Operations***

***April 5, 2010***

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# 1 Introduction

The Provider EDI Reference 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.

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.

# 1.1 Supported EDI Transactions

Highmark will be supporting the following EDI Transactions:

**Provider Transactions**

| | |
|---|---|
| 270 Transaction | Eligibility/Benefit Inquiry |
| 271 Transaction | Eligibility or Benefit Information (response to 270) |
| 276 Transaction | Claim Status Request |
| 277 Transaction | Claim Status Notification (response to 276) |
| 278 Transaction | Two implementations of this transaction:<br>• Services Review — Request for Review (Referral/Authorization Request)<br>• Services Review — Response to Request for Review |
| 837 Transaction | Three implementations of this transaction:<br>• Institutional<br>• Professional<br>• Dental<br>NOTE: Dental transactions (837Ds) for Highmark products must be sent to Highmark's dental associate, United Concordia Companies Inc (UCCI). To receive authorization to submit EDI transactions to UCCI, you must contact Dental Electronic Services at (800) 633-5430. |
| 835 Transaction | Claim Payment/Advice (Electronic Remittance) |

**Employer/Sponsor Transactions**

| | |
|---|---|
| 834 Transaction | Benefit Enrollment and Maintenance |
| 820 Transaction | Premium Payment |

**Acknowledgment Transactions**

| | |
|---|---|
| TA1 Segment | Interchange Acknowledgment |
| 997 Transaction | Functional Group Acknowledgment |
| 277 Acknowledgment | Claim Acknowledgment to the 837 (Provider Transaction) |

## 1.2 Real-Time Transaction Capability

Highmark supports all of the EDI transactions listed in Section 1.1 in batch mode. Additionally, Highmark supports all of the Provider Transactions listed in Section 1.1 in real-time mode. The Acknowledgment Transactions listed in Section 1.1 are also used in real-time mode.

### 1.2.1 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 Reference Guides at the following site:

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

For connectivity specifications related to the Request and Response Inquiry transactions (270/271, 276/277 and 278), see the 'Real-Time Inquiry Connectivity Specifications'.

For connectivity specifications related to Claim Adjudication and Claim Estimation processes (837/835), including a complete 'Transaction Flow' diagram, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications'.

### 1.2.2 Real-Time Claim Adjudication and Estimation

Effective November 7, 2008, Highmark implemented real-time capability for claim adjudication and claim estimation. Both processes leverage the 837 and 835 transactions for these business functions, as well as the 277 Claim Acknowledgment for specific situations.

Real-Time Adjudication - allows providers to submit a claim (837) that is adjudicated in real-time and receive a response (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 a claim (837) for a proposed service and receive a response (835) in real-time. The response 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.

For transaction specific information related to real-time claim adjudication and claim estimation capability, see Chapters:

8 - Professional Claim (837P)

9 - Institutional Claim (837I)

10 - Claim Acknowledgment (277)

11 - Claim Payment Advice (835)

#### 1.2.2.1 General Requirements and Best Practices

Trading Partners must use the ASC X12 National Implementation Guides adopted under the HIPAA Administrative Simplification Electronic Transaction rule and Highmark's EDI Reference guidelines for development of the EDI transactions used in the real-time processes. These documents may be accessed through Highmark's EDI Trading Partner Portal:

https://www.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 (835)
- Claim Status Category Codes and Claim Status Codes (277 Claim Acknowledgement)
- Provider Taxonomy Codes (837)

# 2 General Information

EDI specifications, including this reference guide, can be accessed online at: https://www.highmark.com/edi/resources/guides/index.shtml

## Contact Information

Contact information for EDI Operations:

Address: EDI Operations
P.O. Box 890089
Camp Hill, PA 17089-0089
or
TELEPHONE NUMBER: (717) 302-5170 or
(800) 992-0246
EMAIL ADDRESS: edisupport@highmark.com

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

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

| | |
|---|---|
| Central Region | (866) 731-8080 |
| Western Region | (866) 975-5054 |
| Eastern Region | (866) 975-7290 |
| FEP | (866) 763-3608 |
| Dental (Commercial Products) | (800) 332-0366 |
| Dental (TriCare Dental Programs) | (800) 866-8499 |
| Clarity Vision | (717) 302-5103 |
| 65 Special | (866) 763-6695 |

EDI Operations personnel are available for questions from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

## 2.1 System Operating Hours

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

We strongly suggest that Highmark EDI Trading Partners transmit any test data during the hours that Highmark EDI Operations support is available.

## 2.2 Provider Data Services

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 6). 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.

## 2.3 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.

# 2.4 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.

# 3 Security Features

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.

## 3.1 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.

## 3.2 Authorized Release of Information

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

# 4 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, the Trading Partner to submit production EDI transactions.

Test files may be submitted at the discretion of the Trading Partner.

## 4.1 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 Enrollment Center on our Internet website. You may access the online Application from the page accessed by the link below.

Resource Center
https://www.highmark.com/edi/signup/index.shtml

## 4.2 Receiving 835 Transactions Generated from the Payment Cycle (Batch)

If you are not currently receiving 835 remittance transactions generated from the payment cycle in a batch process and wish to, you will need to complete a new EDI Transaction Application and choose the "Upgrade and Existing Trading Partner" option.

## 4.3 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 an EDI Transaction Application and select the option to "Add a provider to an existing Trading Partner".

## 4.4 Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should complete an EDI Transaction Application and select the option for "Removal of Trading Partner or Provider.

## 4.5 Reporting Changes in Status

Trading Partners changing their information must inform EDI Operations by completing an EDI Transaction Application and including all information that is to be updated.

Resource Center
https://www.highmark.com/edi/signup/index.shtml

## 4.6 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 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.

Mountain State providers submitting transactions for Highmark Health Insurance Company (HHIC) members should refer to the Mountain State Blue Cross Blue Shield's Provider EDI Guide (https://www.msbcbs.com/PDFFiles/Provider-EDI-Guide.pdf) for instructions.

For Medi-CareFirst Members, see Appendix B.

# 5 Testing Policy

Highmark offers two levels of testing to potential trading partners. These levels are described below along with start-up instructions and contacts.

## 5.1 Web Based

The first level is Web-based syntax and validation testing using a Highmark-customized version of Foresight Corporation's HIPAA Validator product. Web-based testing is available for claims where the Interchange Receiver ID (ISA08) is Highmark (54771). Web-based testing is also available for 270 Eligibility, 276 Claim Status, 278 Service Review, 820 Premium Payment, and 834 Enrollment transactions where the payer is Highmark. This testing includes the following types of edits:

- Transaction syntax testing (4010 transaction standards),
- HIPAA data requirements testing (4010A1 Addenda Implementation Guides),
- Front-end acceptance (payer) business rules.

This Web-based testing is available free of charge to our trading partners who have executed a new EDI Trading Partner Agreement. This functionality is designed to make EDI HIPAA syntax and validation testing for Highmark fast, simple, and secure by using a Web-based environment. Testing partners will receive detailed error analysis reports or a notice of successful validation. For more information on Foresight's Validator™, please visit their Web site describing the product at http://foresightcorp.com.

If you need assistance during your Validator™ testing, you may call EDI Operations at 800-992-0246 or e-mail us at *hmhipaatst@highmark.com*. A member of our support staff will be available Monday through Friday 8:00 a.m. to 5:00 p.m. ET to assist with any HIPAA Validator™ Trading Partner Testing questions you may have.

To get started, you need a Highmark Trading Partner ID. This requires completion of an EDI Transaction Application and execution of an EDI Trading Partner Agreement as explained in section 4.1. The

Transaction Application includes a place to request access to the Web-based testing function.

## 5.2 Highmark Transactional Testing

The second level involves connecting to Highmark and submitting a transaction file. Transactions will be taken into Highmark's translator and edited for X12 syntax. For all batch transactions, a functional acknowledgment 997 transaction will be returned indicating the results of the test. For real-time test transactions, a functional acknowledgment 997 will only be returned if a rejection occurs at this level of editing. Note that syntax checking is done for any transaction submitted to Highmark regardless of test or production status of the submitted file.

When the test transaction is an inquiry type request and response transaction (270/271, 276/277) which does not impact/update the adjudication system, the response will be based on data found in the adjudication system.

When testing the batch 837 claim transaction for adjudication, a generic response 277 Claim Acknowledgment (277CA) will be placed in the trading partner's mailbox for retrieval after a successful test. The data contained in the generic 277CA is "canned" and not related to the actual file submitted. Testing for a real-time 837 transaction for claim adjudication cannot be performed due to the potential adjudication system impact or updating. See Section 5.2.1 Highmark Real-Time 837 Estimation Demonstration Process for information on the testing process for a real-time 837 transaction.

NOTE: Highmark is using a 277 Claim Acknowledgment for individual claim responses to an 837 submission. Refer to Chapter 10 - Claim Acknowledgment (277) for additional information on Highmark's implementation of this transaction.

Trading Partners may choose to submit test transactions to Highmark at any time. In order to submit a test file, you must indicate "test" in the ISA segment. Any transactions marked as "production" will be processed against actual production data.

### 5.2.1 Real-Time 837 Claim Estimation Demonstration Process

Highmark's real-time 837 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 837 capabilities will have to do so using the 837 Estimation process.

Professional and Institutional Trading Partners have the ability to validate their secure Internet connection to Highmark, as well as submit an 837 Estimation which will be edited for X12 syntax and Highmark business edits. If the 837 Estimation passes the edits, member liability will be estimated with the end results being returned in a real-time 835 response.

- A functional acknowledgment 997 transaction will be returned in the event that a rejection occurs at the X12 syntax editing level.
- A 277CA transaction will be returned in the event that a rejection occurs as a result of Highmark business editing. The 277CA transaction will return actual editing results
- If the 837 Estimation transaction passes the X12 syntax and Highmark business level edits, a real-time 835 response containing the member's estimated liability and provider's estimated payment will be returned.
- In the event the 837 Estimation cannot be finalized within the real-time process, an accepted 277CA will be returned indicating the 'Estimation cannot be completed in real-time'.

In order to submit a real-time 837 Estimation test transaction, the ISA15 value must be equal to a "T". For more information on HTTPS connectivity specifications for demonstration of 837 Estimation submissions, refer to the Real-Time Claim Adjudication and Estimation Connectivity Specifications. These connectivity specifications are located in the Resources section under EDI Reference Guides at the following site:

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

# 6 Communications

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

- Dial-up (modem-to-modem) is available for transactions in batch mode.
- File Transfer Protocol (FTP) through a secure Internet connection (eDelivery) 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.

## 6.1 Dial-Up / Asynchronous File Transfer

Trading Partners submitting via modem dial a telephone number and establish a reliable link with Highmark. In order to submit electronically via modem, you will need a computer, modem, and software programmed with the option to submit electronically to Highmark. Additionally, a dedicated telephone line for your modem is recommended. Trading Partners should use modems that support the Z modem transfer protocol and incorporate error correction capabilities. Modem baud rates can range up to 56,000.

For transmitting or retrieving transactions, the asynchronous phone numbers are (877) 533-1359 (Toll-Free) and (717) 214-7376 (Toll). *You must use the Toll number when retrieving 835 transactions*. After connecting to Highmark, you will be required to enter your EDI User Logon ID.

### 6.1.1 Dial-Up Command Prompt Option

To reach a command prompt, enter the Logon ID followed by a semicolon(;). You will then be required to enter your password. At that point, you will get to the prompt (PN>). The alpha character in the Logon ID must be entered in lower case. The following is a list of valid commands that can be entered at the prompt.

Note: All of the commands are shown here in upper case. These commands must be entered into the system in lower case (no shift key or shift-lock). The system will always echo the characters back in upper case:

| | |
|---|---|
| XS | Submit any X12 transaction |
| XACK | Retrieve any and all X12 functional acknowledgments |
| XR | Retrieve 835 transactions |
| X271 | Retrieve 271 transactions (response to 270 inquiry) |
| X277 | Retrieve 277 transactions |
| X277U | Retrieve 277 Claim Acknowledgment transactions (unsolicited) |
| X278 | Retrieve 278 transactions |
| X### | Retrieve other X12 response transactions (future) |
| 5001 | Acquire Claim Acknowledgment Report (text format) |

See Section 10 - Claim Acknowledgment for more information on this report.

| | |
|---|---|
| CHPASS | Change Password |
| L | Logoff |

## 6.2 Internet

Highmark offers two methods to utilize the Internet for conducting electronic business with Highmark. The first is secured File Transfer Protocol (FTP) through “eDelivery.” “eDelivery” 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:

- Eligibility Request/Response - 270/271
- Claim Status Request/Response - 276/277
- Health Care Services Review Request/Response - 278/278
- Claim Adjudication or Estimation and Response - 837/835

### 6.2.1 Internet File Transfer Protocol (FTP) through “eDelivery”

The Highmark Secure FTP Server (“eDelivery”) provides an FTP service over an encrypted data session providing “on-the-wire” privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers,

providers, and business partners using a simple FTP process in an encrypted and private manner.

Any state of the art browser can be used to access the Highmark Secure FTP 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. Highmark has tested Internet Explorer 6.x and Netscape 7.x browsers.
2. Connect to the FTP servers at: https://ftp.highmark.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 837 claim transaction file:
    a. Click on the “hipaa-in” folder to change into that directory.
    b. Click on the browse button to select a file from your system to send to Highmark. This will pop open a file finder box listing the files available on your system.
    c. Select the file you wish to send to Highmark and Click on OK.
    d. This will return you to the browser with the file name you selected in the filename window. Now click on the **“Upload File”** button to transfer the file to Highmark. Once completed, the file will appear in your file list.
8. Retrieve a file from Highmark. The following is an example of retrieval of a 997 Functional Acknowledgment file:
    a. Click on the “hipaa-out” directory.

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

c. Click on the “997” 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.

### 6.2.2 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:

- Eligibility Request/Response - 270/271
- Claim Status Request/Response - 276/277
- Health Care Services Review Request/Response - 278/278
- Claim Adjudication or Estimation and Response - 837/835

Real-time transactions utilize Simple Object Access Protocol (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/ SOAP transactions. 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 Reference Guides at the following site:

https://www.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 an 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 997.

# 7 Transmission Envelopes

## 7.1 General Information

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.

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.

### 7.1.1 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 |

| Description | Hex value |
|---|---|
| FormFeed | 0C |
| CarriageReturn | 0D |
| DeviceControl1 | 11 |
| DeviceControl2 | 12 |
| DeviceControl3 | 13 |
| DeviceControl4 | 14 |
| NegativeAcK | 15 |
| SYNchron.Idle | 16 |
| EndTransBlock | 17 |
| FileSeparator | 1C |
| GroupSeparator | 1D |
| RecordSeparator | 1E |
| ! | 21 |
| “ | 22 |
| % | 25 |
| & | 26 |
| ‘ | 27 |
| ( | 28 |
| ) | 29 |
| * | 2A |
| + | 2B |
| , | 2C |
| . | 2E |
| / | 2F |
| : | 3A |
| ; | 3B |
| < | 3C |
| = | 3D |

| Description | Hex value |
|---|---|
| > | 3E |
| ? | 3F |
| @ | 40 |
| [ | 5B |
| ] | 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, "!", can not be used in text data (type AN, Sting data element) within the transaction; reference section 2.5 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 (version 4030 and beyond) | \| | (7C) |

# 7.2 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**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| ISA01 | Authorization Information Qualifier | Highmark can only support code 00 - No Authorization Information present. |
| ISA02 | Authorization Information | This element must be space filled. |
| ISA03 | Security Information Qualifier | Highmark can only support code 00 - No security Information present. |
| ISA04 | Security Information | This element must be space filled. |
| ISA05 | Interchange ID Qualifier | Use qualifier code value "ZZ" Mutually Defined to designate a payer-defined ID. |
| ISA06 | Interchange Sender ID | Use the Highmark assigned security Logon ID. The ID must be left justified and space filled. Any alpha characters must be upper case. |
| ISA07 | Interchange ID Qualifier | Use qualifier code value “33”. Highmark only supports the NAIC code to identify the receiver (Highmark). |
| ISA08 | Interchange Receiver ID | Highmark, designated by NAIC code of 54771, must be identified as the Interchange Receiver except for specific situations defined in the 837P and 276/277 transaction portions of this Reference Guide where Independence Blue Cross, designated by NAIC code 54704, is identified as the Interchange Receiver.<br>• Medi-CareFirst transactions, see Appendix B. |

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| ISA14 | Acknowledgment Requested | Highmark does not consider the contents of ISA14. A TA1 segment is returned when the incoming interchange is rejected. |
| ISA15 | Usage Indicator | Highmark uses the value in this element to determine the test or production nature of all transactions within the interchange. |

## 7.3 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**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| ISA01 | Authorization Information Qualifier | Highmark can only support code 00 - No Authorization Information present. |
| ISA02 | Authorization Information | This element must be space filled. |
| ISA03 | Security Information Qualifier | Highmark can only support code 00 - No security Information present. |
| ISA04 | Security Information | This element must be space filled. |
| ISA05 | Interchange ID Qualifier | Highmark will send qualifier code value "33" to designate that the NAIC code is used to identify the sender. |

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| ISA06 | Interchange Sender ID | Highmark EDI Operations, designated by Highmark's NAIC code of 54771, will be identified as the Interchange Sender except for specific situations defined in the 835 and 276/277 transaction portions of this Reference Guide where Independence Blue Cross, designated by NAIC code 54704, will be identified as the Interchange Sender.<br>• Medi-CareFirst transactions, see Appendix B. |
| ISA07 | Interchange ID Qualifier | 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 logon ID. This ID will be left-justified and space filled. |
| ISA14 | Acknowledgment Requested | Highmark always uses a 0 (No Interchange Acknowledgment Requested). |
| ISA15 | Usage Indicator | Highmark provides T or P as appropriate to identify the test or production nature of all transactions within the interchange. |

## 7.4 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. TA1 segments are not returned for interchanges that do not have interchange-level errors.

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 Appendix B of the national transaction implementation guides. Each Highmark TA1 will have an Interchange control envelope (ISA - IEA).

# 7.5 Outgoing Functional Acknowledgment 997 Transaction

Highmark returns a 997 Functional Acknowledgment for each Functional Group (GS - GE) envelope that is received in a batch mode. In real-time mode, a rejected 997 is returned only when the applicable real-time response transaction can not be returned due to rejections at this level. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of 997 Functional Acknowledgment 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 AK501.) The location and reason for errors are identified in one or more of the following segments:

AK3 - segment errors
AK4 - data element errors
AK5 - transaction errors
AK9 - functional group errors

Rejection reason codes are contained in Appendix B of each transaction's national Implementation Guide. Rejected transactions or functional groups must be fixed and resubmitted.

997 transactions will have Interchange Control (ISA - IEA) and Functional Group (GS - GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the 997 will be "004010", indicating a generic 4010 997 transaction. Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. This difference is because the 997 is generic to the 4010 version and is not unique to each transaction standard.

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 997 will be returned to the submitter. In the following example the AK404 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^U^00401^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^004010
ST^997^0001
AK1^HC^655
AK2^837^PA03
AK3^GS^114^^8
AK4^2^^7^TRADING PARTNER PROFILE
AK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
IEA^1^035738627

Highmark systems apply additional editing on the following inbound transactions: 270 Eligibility Inquiry, 276 Claim Status Inquiry, and 278 Referral / Authorization Request. This additional editing results in rejections that will be returned via the 997 response rather than the current 271, 277, or 278 paired response transactions. The advantage to the trading partner is the ability to make corrections to the inbound files immediately without waiting for the paired transaction outbound responses. These edits include:

- Integrity testing - segment validity, segment sequence, element attributes, X12 syntax and rules.
- Requirement testing - national HIPAA implementation guide situational requirements and usage.
- Situation testing - inter-segment dependencies described in the national HIPAA implementation guides.
- Code set - validation.

# 8 Professional Claim (837P)

The 837 transaction is utilized for professional claims and encounters. The May 2000 ASC X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the October 2002 Addenda document named in the Modifications to Electronic Data Transaction Standards and Code Sets rule is the primary source for definitions, data usage, and requirements.

Companion documents supplement the national guide and addenda with clarifications and payer-specific usage and content requirements.

Sections 8.1 and 8.2 of this Reference Guide make up the companion document for submitting 837 Professional claims for patients with Highmark, Federal Employees Health Benefit Plan, Independence Blue Cross / Highmark joint products, BlueCard Par Point of Service (POS), and Highmark Health Insurance Company (HHIC) and Gateway Vision coverage.

Accurate reporting of NAIC codes to identify the appropriate payer and to control routing is critical for claims submitted to Highmark EDI. The 837P Payer ID Chart immediately following this section contains detailed guidelines for submission of the appropriate NAIC code in each of the following 4 data elements:

- Interchange Receiver ID, ISA08 (always 54771 for these benefit programs)
- Application Receiver, GS03 (54771 or 54771V)
- Receiver ID (1000B NM109) in the 837 transaction (always 54771 for these benefit programs)
- Payer ID (2010BB NM109) in the 837 transaction (54771 or 54771V)

Additional Payers

Medi-CareFirst, see Appendix B.

Highmark will accept Independence Blue Cross EDI with 837P transactions for the following additional payers. See the Independence Blue Cross EDI chart in this section for specific coding instructions.

- Independence Blue Cross - 54704

- AmeriHealth NJ & DE HMO - 95044
- AmeriHealth NJ & DE non-HMO - 60061 & 93688
- AmeriHealth Administrators - 54763
- Independence Administrators - 54763 (or TA720)

Claims for the Additional Payers listed above must be submitted in a separate interchange with an ISA08 Interchange Receiver ID of 54704. Required usage of NAIC codes in the GS03 Application Receiver is shown on the second page of the 837P Payer ID Chart.

## 837P Payer ID Chart

### Send to Highmark EDI

(ISA08 Interchange Receiver ID and 837 Transaction Loop 1000B NM109 Receiver ID = 54771)

| Product | Member ID Alpha Prefix | PAYER<br>Loop 2010BB NM109<br>Payer ID<br>(GS03 Application Receiver MUST match Payer ID) |
|---|---|---|
| Highmark<br>Indemnity, CMM, MM, HMO, PPO, POS (except Personal Choice Network providers), Medicare Supplemental, Federal Employees Health Benefit Plan, Vision. | Various prefixes; "R" for FEHBP; or none. | 54771<br>(54771V for Clarity and Gateway Vision) |
| Independence Blue Cross / Highmark Blue Shield Joint Products | QCD, QCP, QCS, QCT, QCW, YDX | 54771 |
| BlueCard Par Point of Service (POS) | AMS, ATS, NJP, YHF | 54771 |
| BlueCard Par Point of Service (POS)<br>Alpha prefix UPP with Plan Code 362, 363, 378, or blank suitcase | UPP | 54771 |

Independence Blue Cross alpha prefix codes are not valid on a claim submitted to Highmark EDI (Receiver ID 54771), unless a vision claim (Receiver ID 54771V).

## Independence Blue Cross EDI;
## Separate File with ISA08 Interchange Receiver ID = 54704

| Product | GS03 Application Receiver | TRANSACTION<br>Loop 1000B NM109 Receiver ID, and<br><br>Loop 2010BB NM109 Payer ID |
|---|---|---|
| Independence Blue Cross<br>- Blue Choice<br>- Personal Choice<br>- Personal Choice 65<br>- All POS Products for Personal Choice Network Providers | 54704 | See IBC Companion Document |
| Keystone Health Plan East | 95056 | See KHP East Companion Document. Providers in the IBC Area.* |
| AmeriHealth NJ, DE, & PA<br>HMO | 95044 | See AmeriHealth Companion Document |
| AmeriHealth NJ<br>PPO / CMM | 60061 | See AmeriHealth Companion Document |
| AmeriHealth DE<br>PPO | 93688 | See AmeriHealth Companion Document |
| AmeriHealth Administrators (AHA) | 54763 | See AHA Companion Document |
| Independence Administrators (IA)<br>All providers in IBC service area*, and Personal Choice Network Providers outside IBC service area*. | TA720 or 54763 | See IA Companion Document |

* IBC service area includes the following counties: Philadelphia, Bucks, Chester, Delaware and Montgomery.

ALPHA PREFIX LINKS:
The following links provide all of the alpha prefixes associated with IBC and AmeriHealth products:

IBC Payer ID Provider Number Reference
http://www.ibx.com/pdfs/providers/claims_and_billing/edi/ibc_professional_payer_id.pdf

AmeriHealth Payer ID Provider Number Reference
http://www.amerihealth.com/pdfs/providers/claims_and_billing/edi/ah_professional_payer_id.pdf

# 8.1 General Information and Guidelines for Submitting an 837P

## 8.1.1 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 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. (54771 in the Application Receiver GS03 and in the Payer ID loop 2010BB NM109) 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.

### 8.1.1.1 KHP Central Out-of-Area Claims

Under the operating arrangement described in 8.1.1, Highmark is an electronic interface to KHP Central for providers outside the KHP Central Service Area. Those providers can send their electronic KHP Central claims to Highmark. 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. (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 Central. Any payment to the provider will be made by Highmark.

The 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.

#### 8.1.1.2 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 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.

#### 8.1.1.3 Independence Administrators Out-of-Area Claims

Under the BlueCard operating arrangement described in 8.1.1, 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.

#### 8.1.1.4 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.

## 8.1.2 Dental Services

Dental services that are reported with CDT dental procedure codes must be submitted as an 837-Dental 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 an 837-Professional transaction to either Highmark or UCCI according to which payer is responsible for the patient's oral surgery coverage.

## 8.1.3 Data that is Not Used

While the claim information listed below can be (and in some instances must be) contained in a standard claim transaction, Highmark's processing does not currently use the following information:

1. Submitter EDI Contact and Billing Provider Contact (will use contact information on internal files for initial contact)
2. Receiver and Payer name (will use ID, not name)
3. Pay-To provider that is different than the Billing Provider. The payers' business policy does not recognize or enumerate a "Pay-To" provider separate from a "Billing" provider. Therefore, payments will be made to the Billing Provider, even if a Pay-To Provider is submitted in the claim transaction.
4. The provider address from the claim may be used in logic to uniquely identify the provider when an NPI is submitted, but the address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
5. Provider tax number or Social Security Number (will use data on internal files if provider is identified).
6. Currency (information in this CUR segment will not be considered in processing; all electronic transactions will be with trading partners in the U.S.)
7. Subscriber and Patient Secondary Identification (not needed for processing)
8. Patient Information segment including date of death, weight, and pregnancy indicator (not used in processing)

9. Payer Secondary Identification (not needed for processing)
10. Responsible party information (will only use information submitted on appropriate legal documentation and maintained on internal files)
11. Participation indicator, CLM16 (will use participation indication on internal provider files)
12. Contract information in CN1 segment (will use data on internal files)
13. Service Authorization Exception Code (does not apply to payer's business)
14. Purchased Service Provider and Amount (not considered by payer's business policies)
15. Prior Authorization or Referral Number (primary match will be to information on internal files)
16. Investigational Device Exemption Number (not considered by payer's business policies)
17. Ambulatory Patient Group (not used in payer's business arrangements)
18. Demonstration Project Identifier (does not apply to Highmark business)
19. File Information - K3 segment (no use defined)
20. Claim Pricing / Repricing Information (not needed for processing)
21. Provider information in Other Payer Provider Loops 2330D to H (not needed because COB claims are not sent directly to other payers)

### 8.1.4 Transaction Size

As required in the national implementation guide, Highmark can accept up to 5,000 claims per 837 transaction. That is, up to 5,000 "2300" Claim Information loops per ST-SE.

### 8.1.5 Suffix on Highmark's NAIC Code for Vision Claims

For Vision services submitted with this 837P Professional Claim transaction, Highmark requires a "V" suffix on its NAIC code in the Application Receiver Code (GS03), and Payer Identification Code

(loop 2010BB, NM109). Please note that this suffix is only used in this claim transaction and is not used in the other HIPAA transactions. For data elements where Highmark's NAIC code is used in those other transactions, this suffix is not valid. This suffix should only be applied to the claim transaction.

## 8.1.6 Ambulance Claims

Ambulance claims submitted for a SecurityBlue member require identification of the pick-up or point of origin location. In the 4010 version of the transaction, this information can be reported in loop 2310D (Service Facility Location) as follows. The NM1 segment if required; NM101 will have the value '77' (Service Location) and NM102 will have the value '2' (Non-person Entity). The remaining elements are not used. The N2 segment is not used. The N3 (Service Facility Location Address) and N4 (Service Facility Location City/ State/Zip) segments are required for address, city, state, and zip code.

## 8.1.7 Provider and Service Facility Location Identification Numbers

When reporting a Highmark provider or service facility location number, it is important that no leading zero's or alpha characters be submitted along with the Highmark assigned identification number.

When reporting an Employer's Identification Number (EIN) to identify a provider or service facility location, it is important that no hyphens or other special characters be included in the submitted value.

## 8.1.8 Claim Submission Acknowledgment

Highmark is using the 277 Claim Acknowledgment transaction to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the 837 transaction in batch mode. The 277 Claim Acknowledgment is used within the real-time claim process for certain situations when a real-time 835 response could not be generated. Refer to Chapter 10 - Claim Acknowledgment (277) for additional information on Highmark's implementation of this transaction.

For electronic claim submitters using batch mode, that are not able to interpret the 277 Claim Acknowledgment Transaction, a text format Claim Acknowledgment Report has been developed. This report is only produced for acknowledging batch claims submitted to Payer Code 54771. For retrieval of this text format report, see Section 6.1

Command Prompt Options. To print this report, set page orientation to landscape and font size to 8.

NOTE: This text report is NOT available in the real-time claim submission process.

## 8.1.9 National Provider Identifier (NPI)

Highmark can accept the National Provider Identifier (NPI) on electronic claims. General information regarding Highmark's NPI project can be found by selecting the 'HIPAA – National Provider Identifier' link from the Provider Resource Center on Highmark's website. Transaction specifications for submitting claims with the NPI are outlined in the data detail section that follows.

Providers that enumerate their current Highmark provider identifiers in a one-to-one relationship with an NPI will encounter minimal changes to their claim submissions. The only changes that occur are the location within the transaction where the identifiers are sent.

Providers that obtain only one NPI that matches to multiple Highmark IDs will encounter significant transactional changes dependent upon the data required to identify the specific Highmark provider entity that is requesting payment. In these instances, Highmark will utilize additional data from the submitted claim to translate back to the contracted provider entity in order to process the claim. The additional data that may be used includes the taxonomy code, correlating to the contracted specialty of the entity requesting payment, the service location at which services were rendered, and provider name. Following are several scenarios that include examples of the changes that result in the claim submission:

**Scenario 1**

A provider has multiple contracted Highmark provider IDs and elects to enumerate with only one NPI. The difference between the multiple Highmark IDs is different practicing specialties. The location of services rendered is the same across the multiple IDs.

Current:

- Submit Highmark ID plus the Taxonomy code in the Billing Provider loops (Loops 2000A/2010AA) for each separate provider entity.

NPI:

- Submit the same ID for all provider entities, i.e. NPI (Loop 2010AA).
- Submit the taxonomy code (Loop 2000A) for the specific provider entity that rendered services.

**Scenario 2**

A provider has multiple contracted Highmark provider IDs and elects to enumerate with only one NPI. The difference between the multiple Highmark IDs is different practice locations (one per ID). The practicing specialty is the same across the multiple IDs.

Current:

- Submit Highmark ID plus the practice location in the Billing Provider loop (Loop 2010AA).
- The Service Facility location is not sent as all services are rendered at the main location for the provider entity.

NPI:

- Submit the same ID for all provider entities, i.e. NPI (Loop 2010AA).
- Submit the primary location where services are rendered in the Billing Provider loop (Loop 2010AA).
- Submit the location where services were rendered in the Service Facility loop (Loop 2310D) when the location was alternate to the primary location.

## 8.1.10 Balancing

When adjudication by a previous payer is reported, payments and adjustments for that payer must balance. Balancing requirements are listed below. (These requirements are not applied to Host claims, where the subscriber is a member of an out-of-state Blue Cross Blue Shield Plan)

- When a previous payer reports adjudication at the line level, the line item charge amount (2400 SV102) must equal the sum of the line item paid amount (2430 SVD02) plus line level adjustment amounts (2430 CAS) for that payer.
- When a previous payer reports adjudication at the claim level only and not at the line level, the claim level charge amount (2300 CLM02) must equal the sum of the claim level paid amount (2320 AMT) plus claim level adjustment amounts (2320 CAS) for that payer.
- When the claim level charge amount (2300 CLM02) does not equal the claim level paid amount for a previous payer (2320 AMT), there must be adjustment codes and amounts at the claim level (2320 CAS) and/or line level (2430 CAS) for that payer.
- When the claim level paid amount for a previous payer (2320 AMT) does not equal the sum of the line level paid amounts for that payer (2430 SVD02), there must be adjustment codes and amounts at the claim level (2320 CAS) for that payer.

## 8.1.11 Real-Time Claim Adjudication and Estimation

Effective November 7, 2008, Highmark implemented real-time capability for claim adjudication and claim estimation. Both processes leverage the 837 transaction for these business functions. The real-time 837 applies the same business rules and edits as the batch 837. The 837

transaction does not provide an element within the data content to identify whether a real-time 837 adjudication or estimation is being submitted. These functions are defined 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 1.2 Real-Time Transaction Capability.

Real-Time Adjudication - allows providers to submit a claim (837) that is adjudicated in real-time and receive a response (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 a claim (837) for a proposed service and receive a response (835) in real-time. The response 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.

### 8.1.11.1 Real-Time 837 Submission Limitations

The following are limitations of the real-time 837 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 997.
- 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.

### 8.1.11.2 General Requirements and Best Practices

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

- Best Practice: Highmark recommends that the Trading Partner create two processes that will allow Providers to submit claims through their standard method of submission (batch) or through the

new 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 the new real-time process will not be included in the batch process submission, resulting in duplicate claims sent to Highmark.

## 8.2 Data Detail for 837P

The following segment references are clarifications and payer-specific requirements related to data usage and content.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeroes.<br>To support Highmark's routing process for real-time claim adjudication or estimation, the sender's Highmark-assigned Trading Partner number must include a prefix of "R".<br>R = Real-time Claim Request<br><br>Note: For more information on distinguishing the type of real-time 837, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' located in the 'Resources' section under EDI Reference Guides at the following website:<br>https://www.highmark.com/edi/resources/guides/index.shtml |
| GS03 | Application Receiver's Code | Highmark defines this Application Receiver's Code to be identical to the destination payer ID carried in loop 2010BB. This definition leads to a requirement that all claims in a functional group must be for the same payer. Payers are identified by their NAIC code, with a suffix of "V" for Highmark vision claims. Following is a list of recognized payers and their ID codes:<br><br>54771 - Highmark (includes Independence Blue Cross/ Highmark joint products such as Comp Select)<br><br>54771V - Highmark Vision (includes Gateway Health Plan Vision) |
| GS06 | Group Control Number | Highmark does not have specific requirements for this element. |

**Segment:** **REF** **Transmission Type Identification**

**Loop:**

**4010 IG Page:** 66

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF02 | Transmission Type Code | As specified in the national implementation guide, submit value 004010X098A1 designating the addenda version of the standard. Test transmissions are designated by the appropriate code value in the Interchange Control Header segment at ISA15. The submission of a "D" suffix in this REF segment is not necessary to indicate a test transaction, and will not be carried or considered in processing. |

**Segment:** **NM1** **Submitter Name**

**Loop:** 1000A

**4010 IG Page:** 69

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Submitter Identifier | Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zero's. |

**Segment:** **NM1** **Receiver Name**

**Loop:** 1000B

**4010 IG Page:** 75

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Receiver Primary Identifier | Use 54771 - This value identifies Highmark as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. |

**Segment:** **PRV** **Billing/Pay-to Provider Specialty Information**

**Loop:** 2000A Billing/Pay-To Provider

**4010 IG Page:** 79

**Note:** When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, 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.

**Segment:** **N3** **Billing Provider Address**

**Loop:** 2010AA Billing Provider

**4010 IG Page:** 88

**Note:** This N3 segment is the address line for the primary location where the Billing Provider renders services.

**Segment:** **N4** **Billing Provider City/State/Zip**

**Loop:** 2010AA Billing Provider

**4010 IG Page:** 89

**Note:** This N4 segment is the city, state, and Zip Code for the primary location where the Billing Provider renders services.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| N403 | Postal Code | The 9-digit Zip + 4 Code will result in faster and more accurate processing when the provider does not obtain an NPI for each Highmark legacy ID. |

**Segment:** **SBR** **Subscriber Information**

**Loop:** 2000B

**4010 IG Page:** 111

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| SBR03 | Group Number | For fastest processing, submit if listed on the subscriber's Health Care ID Card. |
| SBR04 | Group Name | For fastest processing, submit if subscriber's Health Care ID Card includes a Group Name but not a Group Number. |

**Segment:** **NM1** **Subscriber Name**
**Loop:** 2010BA
**4010 IG Page:** 119

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Identification Code | 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. |

**Segment:** **NM1** **Payer Name**
**Loop:** 2010BB
**4010 IG Page:** 131

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Payer Identifier | Submit the NAIC number for the destination payer. Add a suffix of "V" for Highmark vision claims. Following is a list of recognized payers and their respective NAIC codes:<br><br>54771 - Highmark (includes Independence Blue Cross/ Highmark joint products such as Comp Select)<br><br>54771V - Highmark Vision (includes Gateway Health Plan Vision) |

**Segment:** **NM1** **Patient Name**

**Loop:** 2010CA

**4010 IG Page:** 159

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Patient Primary 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. |

**Segment:** **CLM** **Claim Information**

**Loop:** 2300

**4010 IG Page:** 173

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| CLM05-3 | Claim Frequency Type Code | Available code values are defined in the National Uniform Billing Committee's (NUBC's) documentation of the Claim Frequency Code, which is the third position of the Uniform Billing Claim Form Bill Type. 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. |

**Segment:** **DTP** **Date - Date Last Seen**

**Loop:** 2300, 2400

**4010 IG Page:** 186, 445

**Note:** This date is not needed for the payer's adjudication process; therefore, the date is not required.

**Segment:** **DTP** **Date - Admission**

**Loop:** 2300

**4010 IG Page:** 208

**Note:** Reporting of admission dates on all inpatient services will result in more accurate processing when that date is needed to apply business policy.

**Segment:** **PWK** **Claim Supplemental Information**

**Loop:** 2300

**4010 IG Page:** 214

**Note1:** 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.

**Note 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.

**Note 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 EDI website at:

https://www.highmark.com/edi/pdfs/Claim_Suppl_Info_Cover_Sheet.pdf

**Note 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.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PWK01 | Attachment Report 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 | Highmark's business practices and policy only support the following transmission types at this time:<br>• AA - Available on Request<br>• BM - By mail; mail to Highmark Attachments, PO Box 890176, Camp Hill PA 17089-0176<br>• FX - By fax; fax to 717-302-3686. |

**Segment:** **AMT** **Total Purchase Service Amount**

**Loop:** 2300

**4010 IG Page:** 221

**Note:** This amount is not needed for the payer's adjudication process; therefore, the amount is not required.

**Segment:** **REF** **Mammography Certification Number**

**Loop:** 2300

**4010 IG Page:** 226

**Note:** This certification number must be submitted on claims for mammography services by a certified mammography provider.

**Segment:** **CR2** **Spinal Manipulation Information**

**Loop:** 2300

2400

**4010 IG Page:** 251, 415

**Note:** This segment is not needed for the payer's adjudication process; therefore, the segment is not required.

**Segment:** **CRC** **Patient Condition Information - Vision**

**Loop:** 2300

**4010 IG Page:** 260

**Note:** This information is needed for the payer's vision claim adjudication process; therefore, the segment must be sent on vision claims involving replacement lenses or frames.

**Segment:** **PRV** **Referring Provider Specialty Information**

**Loop:** 2310A

**4010 IG Page:** 285

**Note:** When the Referring Provider's National Provider Identifier (NPI) is sent in the 2310A Referring Provider NM109, Highmark's business processes require the Provider Taxonomy Code, correlating to the contracted specialty, be submitted.

**Segment:** **NM1** **Rendering Provider Name**

**Loop:** 2310B

**4010 IG Page:** 290

**Note:** Highmark requires that the individual provider who performed the service be identified in this 2310B Rendering Provider loop when the Provider Group (Assignment Account) is reported as the Billing Provider in loop 2010AA. This includes one-person provider corporations when the corporation and individual have separate Highmark assigned provider numbers.

The provider identified in this 2310B loop applies to all service lines in this claim unless a different Rendering Provider is submitted in the 2420B loop within a service line.

**Segment:** **PRV** **Rendering Provider Specialty Information**

**Loop:** 2310B

**4010 IG Page:** 293

**Note:** When the Rendering Provider's National Provider Identifier (NPI) is sent in the 2310B Rendering Provider NM109, Highmark's business processes require the Provider Taxonomy Code, correlating to the contracted specialty, be submitted.

**Segment:** **NM1** **Service Facility Location**

**Loop:** 2310D

**4010 IG Page:** 303

**Note:** Note 1: Highmark requires that information about the location where the service was performed be submitted in this segment and loop when the service was performed at a secondary location and the provider's primary location was sent in the Billing Provider loops.

Note 2: Highmark requires that this segment, including the National Provider Identifier (NPI) of the service location, be submitted when the Place of Service reported in the CLM05-1 is one of the following:

21 - Inpatient Hospital
22 - Outpatient Hospital
23 - Emergency Room - Hospital
31 - Skilled Nursing Facility
32 - Nursing Facility
51 - Inpatient Psychiatric Facility
61 - Comprehensive Inpatient Rehabilitation Facility

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM1 08/ 09 | Facility Primary Identifier | -The facility's NPI is required when the Place of Service is one of those listed in Note 2 above.<br>-When an identifier is sent for a Place of Service not on the list in Note 2 above, that identifier must be the facility's NPI. |

**Segment:** **N3** **Service Facility Location Address**

**Loop:** 2310D

**4010 IG Page:** 307

**Note:** When this 2310D Service Facility Location loop is used, this N3 segment is the address of the location at which the service was performed.

**Segment:** **N4** **Service Facility Location City/State/Zip**

**Loop:** 2310D

**4010 IG Page:** 308

**Note:** When this 2310D Service Facility Location loop is used, this N4 segment is the city/state/zip of the location at which the service was performed.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| N403 | Postal Code | The 9-digit Zip + 4 Code will result in faster and more accurate processing when the provider did not obtain an NPI for each Highmark legacy ID. |

**Segment:** **SBR** **Other Subscriber Information**

**Loop:** 2320

**4010 IG Page:** 318

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| SBR05 | Insurance Type Code | When the prior payer is Medicare (Part A, Part B, or Medicare Advantage), use one of the following values:<br><br>CP Medicare Conditionally Primary<br>MB Medicare Part B<br>MP Medicare Primary |
| SBR09 | Claim Filing Indicator Code | When the prior payer is Medicare (Part A, Part B, or Medicare Advantage), use one of the following values:<br><br>16 Health Maintenance Organization (HMO) Medicare Risk<br>MB Medicare Part B |

**Segment:** **AMT** **COB Patient Paid Amount**

**Loop:** 2320

**4010 IG Page:** 339

**Note:** This COB Patient Paid Amount AMT segment should not be used. The national standards group has confirmed that an oversight resulted in two places for reporting this amount in the 4010 Implementation Guide, this 2320 AMT and the 2320 CAS. Therefore, this usage of the AMT segment will be removed in the next version of the guide. The amount (previous payer paid to the patient) will be reported to the provider in the previous payer's 835 remittance in a CAS segment, and therefore can and should be reflected in the CAS segment (2320 loop) in an 837 claim to a secondary payer.

The amount that the patient paid to the provider is not reported in this segment; rather, that amount is placed in the Patient Paid Amount AMT in the 2300 loop.

**Segment:** **NM1** **Other Payer Name**
**Loop:** 2330B
**4010 IG Page:** 361

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| 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.<br><br>Use a unique number that identifies the other payer in the submitter's system. As specified in the national implementation guide, if line level adjudication information from this other payer is being submitted in the 2430 Service Line Adjudication Information loop, it is critical that the Other Payer ID number in this 2330B element match exactly the Payer Identifier in the SVD01 element of the 2430 loop.<br><br>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 within this transaction. |

**Segment:** **SV1** **Service Line**

**Loop:** 2400

**4010 IG Page:** 400

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| SV101-1 | Service ID Qualifier | 1) Drug charges should be reported with the appropriate HCPCS j-code. National Drug Codes (NDC) are not reported in this data element. Starting with the addenda version of the 4010 transaction, NDC codes can be reported in the 2410 Drug Identification loop.<br><br>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 this transaction. |
| SV101-3<br>SV101-4<br>SV101-5<br>SV101-6 | Procedure Modifier | For anesthesia services where the billing provider is not a Certified Registered Nurse Anesthetist (CRNA), Highmark requires submission of one of the following anesthesia certification modifiers: AA, AD, GC, QK, QX, QY, or 47. If the billing provider is not participating and is not in Pennsylvania, code values QZ is also valid.<br><br>For anesthesia services where the billing provider is a CRNA, Highmark requires submission of one of the following anesthesia certification modifiers: QX or QZ. If the billing provider is not participating and not in Pennsylvania, code values AA, AD, GC, QK, QY, and 47 are also valid. |
| SV103 | Unit Measurement Code | For anesthesia services, the payer's business policy requires that minutes are reported. Therefore, for anesthesia services, the code value in SV103 must be MJ, Minutes, and the actual number of minutes are reported in SV104. Note that Moderate (Conscious) Sedation Codes (after April 16, 2010) 99143 - 99145 and 99148 - 99150, or anesthesia modifying unit procedure codes 99110, 99116, 99135 or 99140 are reported with UN, Units, and not minutes. |

**Segment:** **AMT** **Sales Tax Amount**

**Loop:** 2400

**4010 IG Page:** 484

**Note:** The payers' business policies require that sales tax, if applicable, be reported as a separate service line with the appropriate national procedure code, not combined with the provider's charge for the service. Therefore, this AMT segment is not used in claims built under this reference guide.

**Segment:** **PS1** **Purchase Service Information**

**Loop:** 2400

**4010 IG Page:** 489

**Note:** This information is not needed for the payer's adjudication process; therefore, it is not required.

**Segment:** **LIN** **Drug Identification**

**Loop:** 2410

**4010 IG Page:** Addenda page 71 (not in 4010 IG)

**Note 1:** Use this segment to report NDC codes for Home Infusion Therapy and drugs that are part of Home Health services.

**Note 2:** NDC codes are required when specified in the Provider's agreement with Highmark.

**Note 3:** Highmark encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.

**Segment:** **CTP** **Drug Pricing**

**Loop:** 2410

**4010 IG Page:** Addenda page 75 (not in 4010 IG)

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| CTP03 | Unit Price | Maximum length is 10 characters including reported or implied cents. |

**Note 1:** Highmark requires the information in this Drug Pricing segment in order to utilize the NDC in payment calculations.

**Segment:** **NM1** **Rendering Provider Name**

**Loop:** 2420A

**4010 IG Page:** 501

**Note:** A Rendering Provider submitted in this 2420A loop overrides the Rendering Provider in the 2310B loop for this service line. The 2420A loop can not be used without a 2310B loop on this claim.

**Segment:** **PRV** **Rendering Provider Specialty Information**

**Loop:** 2420A

**4010 IG Page:** 504

**Note:** When the Rendering Provider's National Provider Identifier (NPI) is sent in the 2420A Rendering Provider NM109, Highmark's business processes require the Provider Taxonomy Code, correlating to the contracted specialty, be submitted.

**Segment:** **REF** **Service Facility Location Secondary Identification**

**Loop:** 2420C

**4010 IG Page:** 521

**Note:** When the 2420C Service Facility Location loop is used, this segment must contain the Tax Identification Number for the facility when the National Provider Identifier (NPI) is not sent in the NM109 of this loop.

**Segment:** **PRV** **Referring Provider Specialty Information**

**Loop:** 2420F

**4010 IG Page:** 544

**Note:** When the Referring Provider's National Provider Identifier (NPI) is sent in the 2420F Referring Provider NM109, Highmark's business processes require the Provider Taxonomy Code, correlating to the contracted specialty, be submitted.

# 9 Institutional Claim (837I)

The 837 transaction is utilized for professional claims and encounters. The May 2000 ASC X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the October 2002 Addenda document named in the Modifications to Electronic Data Transaction Standards and Code Sets rule is the primary source for definitions, data usage, and requirements.

Companion documents supplement the national guide and addenda with clarifications and payer-specific usage and content requirements.

Highmark

Sections 9.1 and 9.2 of this Reference Guide make up the companion document for submitting 4010A1 837I claim transactions for Highmark:

- Highmark - 54771
  (includes Highmark Indemnity, Preferred Provider Organization PPO, Point of Service POS, Health Maintenance Organization HMO, Comprehensive Major Medical CMM, Major Medical, Highmark Health Insurance Company (HHIC) and Medicare Supplemental)

Required usage of NAIC codes in the ISA, GS and 837 is shown in the table at the end of this section.

Additional Payers

- Medi-CareFirst, see Appendix B

# 837I Payer ID Chart

## Send to Highmark EDI

(ISA08 Interchange Receiver ID and 837 Transaction Loop 1000B NM109 Receiver ID = 54771)

| Product | Member ID Alpha Prefix | PAYER<br>Loop 2010BC<br>NM109 Payer ID<br>(GS03 Application Receiver MUST match Payer ID) | Companion Document |
|---|---|---|---|
| Highmark<br>Indemnity, CMM, MM, HMO, PPO, POS, Medicare Supplemental, Federal Employees Health Benefit Plan. | Various prefixes; "R" for FEHBP; or none. | 54771W (Western Region)<br>54771C (Central Region) | Highmark |

# 9.1 General Information and Guidelines for Submitting an 837I

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

For patients with coverage from an out-of-state Plan, an operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark to accept 837I claims from those facility providers that send their Highmark 837I claims to Highmark EDI. 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 2010BC 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.

### 9.1.1.1 KHP Central Out-of-Area Claims (Western Region)

Under the operating arrangement described in 9.1.1, Highmark is an electronic interface to KHP Central for facility providers outside the KHP Central Service Area that send their Highmark 837I claims to Highmark EDI. Those providers can send their electronic KHP Central claims to Highmark. 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. (accomplished by reporting "54771W" in the NM109 Payer ID element of the 2010BC Payer Name loop) Highmark will use the Member ID alpha prefix to identify the need to coordinate processing with KHP Central. Any payment to the provider will be made by Highmark.

The 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.

## 9.1.2 Data that is Not Used

While the claim information listed below can be (and in some instances must be) contained in a standard claim transaction, Highmark's processing does not currently use the following information:

1. Submitter EDI Contact and Billing Provider Contact (will use contact information on internal files for initial contact)
2. Receiver and Payer name (will use ID, not name)
3. Pay-To provider that is different than the Billing Provider. The payers' business policy does not recognize or enumerate a "Pay-To" provider separate from a "Billing" provider. Therefore, payments will be made to the Billing Provider, even if a Pay-To Provider is submitted in the claim transaction.
4. The provider address from the claim may be used in logic to uniquely identify the provider when an NPI is submitted, but the address on Highmark's internal files will be used for mailing of a check or other documents related to the claim.
5. Provider tax number or Social Security Number (will use data on internal files if provider is identified).
6. Currency (information in this CUR segment will not be considered in processing; all electronic transactions will be with trading partners in the U.S.)
7. Subscriber and Patient Secondary Identification (not needed for processing)
8. Patient Information segment including date of death, weight, and pregnancy indicator (not used in processing)
9. Payer Secondary Identification (not needed for processing)
10. Responsible party information (will only use information submitted on appropriate legal documentation and maintained on internal files)
11. Contract information in CN1 segment (will use data on internal files)
12. Investigational Device Exemption Number (not considered by payer's business policies)

13. Peer Review Organization Approval Number (will match against information on internal files)
14. Prior Authorization or Referral Number (primary match will be to information on internal files)
15. Demonstration Project Identifier (does not apply to Highmark business)
16. File Information - K3 segment (no use defined)
17. Treatment Code Information - HI segment (Home Health Agency treatment plan information is not needed for processing)
18. Claim Pricing / Repricing Information (not needed for processing)
19. Provider identifiers and related provider information in the Other Payer Provider loops (Loop IDs 2330D, E, F, and H)
20. Medicare PPS Assessment Date (not needed for processing)

### 9.1.3 Transaction Size

As required in the national implementation guide, Highmark can accept up to 5,000 claims per 837 transaction. That is, up to 5,000 "2300" Claim Information loops per ST-SE.

### 9.1.4 Number of Lines per Claim

Highmark accepts 837I institutional claims with up to 999 lines per claim in batch mode. Real-time 837I submissions are limited to 50 lines per claim.

### 9.1.5 Suffix on Highmark's NAIC Code

For this 837I Institutional Claim transaction, Highmark requires a "W" or "C" suffix on its NAIC code in the Application Receiver Code (GS03), and Payer Identification Code (loop 2010BC, NM109). Please note that this suffix is only used in this claim transaction and is not used in the other HIPAA transactions. For data elements where Highmark's NAIC code is used in those other transactions, these suffixes are not valid. These suffixes should only be applied to the claim transaction.

### 9.1.6 Standalone Major Medical

Standalone Major Medical refers to situations where a member has Major Medical benefits, and the services are not covered by the

member's basic medical/surgical benefits. That is, the only applicable benefit is Major Medical. Such claims can be submitted electronically by following the directions for the loop 2300 CN1 Contract Information segment in this reference guide.

## 9.1.7 Provider Identification Numbers

When reporting a Highmark provider number, it is important that no leading zero's or alpha characters be submitted along with the Highmark assigned identification number.

When reporting an Employer's Identification When reporting an Employer's Identification Number (EIN) to identify a provider, it is important that no hyphens or other special characters be included in the submitted value.

## 9.1.8 Claim Submission Acknowledgment

Highmark is using the 277 Claim Acknowledgment transaction to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the 837 transaction in batch mode. The 277 Claim Acknowledgment is used within the real-time claim process for certain situations when a real-time 835 response could not be generated. Refer to Chapter 10 - Claim Acknowledgment (277) for additional information on Highmark's implementation of this transaction.

For electronic claim submitters using batch mode that are not able to interpret the 277 Claim Acknowledgment Transaction, a text format Claim Acknowledgment Report has been developed. This report is only produced for acknowledging batch claims submitted to Payer Code 54771. For retrieval of this text format report, see Section 6.1 Command Prompt Options. To print this report, set page orientation to landscape and font size to 8.

NOTE: This text report is NOT available in the real-time claim submission process.

## 9.1.9 National Provider Identifier (NPI)

Highmark can accept the National Provider Identifier (NPI) on electronic claims. General information regarding Highmark’s NPI project can be found by selecting the ‘HIPAA – National Provider Identifier’ link from the Provider Resource Center on Highmark’s website. Transaction specifications for submitting claims with the NPI are outlined in the data detail section that follows.

Providers that enumerate their current Highmark provider identifiers in a one-to-one relationship with an NPI will encounter minimal changes to their claim submissions. The only changes that occur are the location within the transaction where the identifiers are sent.

Providers that obtain only one NPI that matches to multiple Highmark IDs will encounter significant transactional changes dependent upon the data required to identify the specific Highmark provider entity that is requesting payment. In these instances, Highmark will utilize additional data from the submitted claim to translate back to the contracted provider entity in order to process the claim. The additional data that may be used includes the taxonomy code, correlating to the contracted specialty of the entity requesting payment, the service location at which services were rendered, and provider name. Following are several scenarios that include examples of the changes that result in the claim submission:

**Scenario 1**

A provider has multiple contracted Highmark provider IDs and elects to enumerate with only one NPI. The difference between the multiple Highmark IDs is different practicing specialties. The location of services rendered is the same across the multiple IDs.

Current:

- Submit Highmark ID plus the Taxonomy code in the Billing Provider loops (Loops 2000A/2010AA) for each separate provider entity.

NPI:

- Submit the same ID for all provider entities, i.e. NPI (Loop 2010AA).
- Submit the taxonomy code (Loop 2000A) for the specific provider entity that rendered services.

**Scenario 2**

A provider has multiple contracted Highmark provider IDs and elects to enumerate with only one NPI. The difference between the multiple Highmark IDs is different practice locations (one per ID). The practicing specialty is the same across the multiple IDs.

Current:

- Submit Highmark ID plus the practice location in the Billing Provider loop (Loop 2010AA).

- The Service Facility location is not sent as all services are rendered at the main location for the provider entity.

NPI:

- Submit the same ID for all provider entities, i.e. NPI (Loop 2010AA).
- Submit the primary location where services are rendered in the Billing Provider loop (Loop 2010AA).
- Submit the location where services were rendered in the Service Facility loop (Loop 2310E) when the location was alternate to the primary location.

## 9.1.10 Balancing

When adjudication by a previous payer is reported, payments and adjustments for that payer must balance. Balancing requirements are listed below. (These requirements are not applied to Host claims, where the subscriber is a member of an out-of-state Blue Cross Blue Shield Plan)

- When a previous payer reports adjudication at the line level, the line item charge amount (2400 SV203) must equal the sum of the line item paid amount (2430 SVD02) plus line level adjustment amounts (2430 CAS) for that payer.
- When a previous payer reports adjudication at the claim level only and not at the line level, the claim level charge amount (2300 CLM02) must equal the sum of the claim level paid amount (2320 AMT) plus claim level adjustment amounts (2320 CAS) for that payer.
- When the claim level charge amount (2300 CLM02) does not equal the claim level paid amount for a previous payer (2320 AMT), there must be adjustment codes and amounts at the claim level (2320 CAS) and/or line level (2430 CAS) for that payer.
- When the claim level paid amount for a previous payer (2320 AMT) does not equal the sum of the line level paid amounts for that payer (2430 SVD02), there must be adjustment codes and amounts at the claim level (2320 CAS) for that payer.

## 9.1.11 Real Time Claim Adjudication and Estimation

Effective November 7, 2008, Highmark implemented real-time capability for claim adjudication and claim estimation. Both processes leverage the 837 transaction for these business functions. The real-time

837 applies the same business rules and edits as the batch 837. The 837 transaction does not provide an element within the data content to identify whether a real-time 837 adjudication or estimation is being submitted. These functions are defined 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 1.2 Real-Time Transaction Capability.

Real-Time Adjudication - allows providers to submit a claim (837) that is adjudicated in real-time and receive a response (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 a claim (837) for a proposed service and receive a response (835) in real-time. The response 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.

### 9.1.11.1 Real-Time 837 Submission Limitations

The following are limitations of the real-time 837 process:

- The real-time claim adjudication and estimation submission process is limited to a single claim with no more than 50 lines of service (1 Loop 2300 - Claim Information) within an Interchange (ISA-IEA). Transmissions with more than a single claim will receive a rejected 997.
- Facility claims with greater than 50 lines of service should continue to be submitted through the batch process.
- 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.

### 9.1.11.2 General Requirements and Best Practices

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

- Best Practice: Highmark recommends that the Trading Partner create two processes that will allow Providers to submit claims through their standard method of submission (batch) or through the new 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 the new real-time process will not be included in the batch process submission, resulting in duplicate claims sent to Highmark.

## 9.2 Data Detail for 837I

The following segment references are clarifications and payer-specific requirements related to data usage and content.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zeroes.<br>To support Highmark's routing process for real-time claim adjudication or estimation, the sender's Highmark-assigned Trading Partner number must include a prefix of "R".<br>R = Real-time Claim Request<br><br>Note: For more information on distinguishing the type of real-time 837 claim request, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' located in the 'Resources' section under EDI Reference Guides at the following website:<br>https://www.highmark.com/edi/resources/guides/index.shtml |

## Data Element Summary

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS03 | Application Receiver's Code | Highmark defines this Application Receiver's Code to be identical to the destination payer ID carried in loop 2010BC. This definition leads to a requirement that all claims in a functional group must have the same payer ID value. Submit Highmark's NAIC number, and appropriate suffix as indicated below. Note that Highmark's business policy requires a suffix; the claim will be returned if a suffix is not appended to the 54771 NAIC code. The value in this element should correspond to the NAIC number and suffix submitted as the payer ID in the Payer Name segment in loop 2010BC.<br>• Value to be submitted by a facility in Highmark's Central Region (Plan Code 378): **54771C**<br>• Value to be submitted by a facility in the 29 counties of Highmark's Western Region (Plan Code 363): **54771W** |
| GS06 | Group Control Number | Highmark does not have specific requirements for this element. |

**Segment:** **REF** **Transmission Type Identification**
**Loop:**
**4010 IG Page:** 60

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF02 | Transmission Type Code | As specified in the national implementation guide, submit value 004010X096A1 designating the addenda version of the standard. Test transmissions are designated by the appropriate code value in the Interchange Control Header segment at ISA15. The submission of a "D" suffix in this REF segment is not necessary to indicate a test transaction, and will not be carried or considered in processing. |

**Segment:** **NM1** **Submitter Name**
**Loop:** 1000A
**4010 IG Page:** 63

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Submitter Identifier | Sender's Highmark assigned Trading Partner Number. The submitted value must not include leading zero's. |

**Segment:** **NM1** **Receiver Name**

**Loop:** 1000B

**4010 IG Page:** 68

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Receiver Primary Identifier | Use 54771 - This value identifies Highmark as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. |

**Segment:** **PRV** **Billing/Pay-To Provider Specialty Information**

**Loop:** 2000A Billing/Pay-To Provider

**4010 IG Page:** 71

**Note:** When the Billing Provider's National Provider Identifier (NPI) is sent in the 2010AA Billing Provider NM109, Highmark's business processes require the Provider Taxonomy Code, correlating to the contracted specialty, be submitted.

When the Billing Provider has subparts with different specialties but does not enumerate these subparts with separate NPIs, this taxonomy must be for the subpart that is requesting payment.

**Segment:** **N3** **Billing Provider Address**

**Loop:** 2010AA

**4010 IG Page:** 79

**Note:** This N3 segment is the address line for the primary location where the Billing Provider renders services.

**Segment:** **N4** **Billing Provider City/State/Zip**

**Loop:** 2010AA

**4010 IG Page:** 80

**Note:** This N4 segment is the city, state, and zip code for the primary location where the Billing Provider renders services.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| N403 | Postal Code | The 9-digit Zip + 4 Code will result in faster and more accurate processing when the provider does not obtain an NPI for each Highmark legacy ID. |

**Segment:** **SBR** **Subscriber Information**

**Loop:** 2000B

**4010 IG Page:** 103

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| SBR03 | Group Number | For fastest processing, submit if listed on the subscriber's Health Care ID Card. |
| SBR04 | Group Name | For fastest processing, submit if subscriber's Health Care ID Card includes a Group Name but not a Group Number. |

**Segment:** **NM1** **Subscriber Name**
**Loop:** 2010BA
**4010 IG Page:** 110

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Identification Code | 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. |

**Segment:** **NM1** **Payer Name**
**Loop:** 2010BC
**4010 IG Page:** 128

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Identification Code | Submit Highmark's NAIC number, and the appropriate suffix as indicated below. Note that Highmark's business policy requires a suffix; the claim will be returned if a suffix is not appended to the 54771 NAIC code.<br>• Value to be submitted by a facility in Highmark's Central Region (Plan Code 378): **54771C**<br>• Value to be submitted by a facility in the 29 counties of Highmark's Western Region (Plan Code 363): **54771W** |

**Segment:** **NM1** **Patient Name**
**Loop:** 2010CA
**4010 IG Page:** 147

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Identification Code | 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. |

**Segment:** **CLM** **Claim Information**
**Loop:** 2300
**4010 IG Page:** 161, 163

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| CLM18 | EOB Indicator | This indicator will not alter Highmark's normal business practice for issuance of EOBs and remittance advices. |

**Segment:** **DTP** **Discharge Hour**
**Loop:** 2300
**4010 IG Page:** 166

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| DTP03 | Discharge 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.<br><br>Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'. |

**Segment:** **DTP** **Admission Date / Hour**
**Loop:** 2300
**4010 IG Page:** 170

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| 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.<br><br>Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'. |

**Segment:** **PWK** **Claim Supplemental Information**

**Loop:** 2300

2400

**4010 IG Page:** 173, 452

**Note1:** Attachments associated with a PWK (paperwork) segment should be sent (via fax or mail) at the same time the 837 HIPAA claims 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 of the 837 thereby resulting in development or denial of your claim.

**Note2:** 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.

**Note3:** A PWK Supplemental Clain 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 EDI website at:

https://www.highmark.com/edi/pdfs/
Claim_Suppl_Info_Cover_Sheet.pdf

**Note 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.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PWK01 | Report Type Code | Highmark may be able to adjudicated your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" (Support Data for Claim). |
| PWK02 | Report Transmission Code | Highmark's business practices and policy only support the following transmission types at this time:<br>• AA - Available on Request at Provider Site.<br>• BM - By Mail; mail to Highmark Attachments, PO Box 890176, Camp Hill PA 17089-0176.<br>• FX - By Fax; fax to 717-302-3686 |

**Segment:** **CN1** **Contract Information**

**Loop:** 2300

**4010 IG Page:** 176, 177

**Note:** Major Medical - This segment is used to designate that the claim is submitted for consideration under the member's Major Medical coverage. Highmark will process under the Major Medical benefit program when CN101 has a value of "09" and CN104 has a value of "MM".

**Segment:** **REF** **Original Reference Number (ICN/DCN)**

**Loop:** 2300

**4010 IG Page:** 191

**Note:** 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.

**Segment:** **K3** **File Information**

**Loop:** 2300

**4010 IG Page:** 204

**Note:** Use the K3 segment to report Present on Admission (POA) indicators associated with Principal and Other Diagnosis Codes. Detailed POA reporting requirements will be communicated through a Highmark facility bulletin.

**Data Element Summary**

| Ref. Des. | Element Name | Element Note |
|---|---|---|
| K301 | Fixed Format Information | The fixed format for reporting POA's is as follows:<br>• Positions 1 - 3 = POA<br>• Position 4 = POA Indicator for the Principal Diagnosis (HI segment with BK qualifier)<br>• Positions 5 - ? = POA indicators for all Other Diagnosis Codes (HI segment with BF qualifier) that are reported.<br>• Next position = End of List code follows the last Principal or Other Diagnosis POA indicator. If no Other Diagnosis Codes are reported, the End of List code will be in position 5.<br>• Next position = POA Indicator for External Cause of Injury Code (E-Code), if an E-Code is reported on this claim.<br><u>POA Indicator Values</u><br>Y = Yes<br>N = No<br>U = Unknown<br>W = Clinically undetermined<br>1 = Diagnosis code is exempt from reporting of POA<br><br><u>End of List Code Values</u><br>Z = Indicates the end of diagnosis code POA indicators.<br>X = Indicates the end of diagnosis code POA indicators when there are special processing situations (exception handling).<br><br><u>Examples</u><br>K3*POAYNUZY~ No exception handling; e-code reported.<br>K3*POANZ~ No exception handling; no e-code reported.<br>K3*POAY1XY~ Exception handling; e-code reported. |

**Segment:** **HI** **Principal Procedure Information**

**Loop:** 2300

**4010 IG Page:** 242

**Note:** The payers' business policy and pricing require that partial hospitalizations for detoxification be considered as inpatient, and thereby require that a principal procedure must be submitted, using an ICD-9-CM procedure code. A partial hospitalization occurs when the patient is hospitalized for the day or a portion of the day, but does not stay overnight.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| HI01 | Health Care Code Information | As required by the federal Electronic Transaction rule, ICD-9-CM procedure codes (qualifier BR) must be used to report hospital inpatient services.<br><br>Procedure codes for outpatient services must be reported in the Service Line SV2 segment. Procedure codes for outpatient services other than Home IV Therapy that are reported in this HI segment will not be considered in processing. |

**Segment:** **HI** **Other Procedure Information**

**Loop:** 2300

**4010 IG Page:** 244

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| HI01 | Health Care Code Information | As required by the federal Electronic Transaction rule, only ICD-9-CM procedure codes (qualifier BQ) must be used to report hospital inpatient services.<br><br>Procedure codes for outpatient services must be reported in the Service Line SV2 segment. Procedure codes for outpatient services other than Home IV Therapy that are reported in this HI segment will not be considered in processing. |

**Segment:** **HI** **Value Information**

**Loop:** 2300

**4010 IG Page:** 280

**Note:** The UB-04 code manual defines the following Value Codes as not valid on electronic claims: 80 - 83, A1 - A3, A7, B1 - B3, B7, C1 - C3, C7. Amounts corresponding to these payment reductions must be coded as CAS adjustment amounts in the Other Payer segments of the electronic claim.

**Segment:** **NM1** **Attending Physician, Operating Physician, and Other Provider Name**

**Loop:** 2310A Attending Physician

2310B Operating Physician

2310C Other Provider

**4010 IG Page:** 323, 330, 337

**Note:** This "Primary Identifier" is not required for processing. In order to satisfy the transaction syntax requirements, a default of all "9's" may be used if the actual National Provider Identifier (NPI) is not available to the submitter.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Attending Physician, Operating Physician, and Other Provider Primary Identifier | This "primary identifier" is not required for processing. In order to satisfy the transaction syntax requirements, a default of all "9"s may be used if the actual Employer's Identification Number (EIN) or Social Security Number (SSN) is not available to the submitter. |

**Segment:** **PRV** **Attending Physician Specialty Information**

**Loop:** 2310A

**4010 IG Page:** 324

**Note:** When the Attending Physician's National Provider Identifier (NPI) is sent, submission of the taxonomy code correlating to the contracted specialty may enable faster, automated processing in situations that would otherwise require manual verification of the provider's NPI.

**Segment:** **NM1** **Service Facility Name**

**Loop:** 2310E

**4010 IG Page:** 349

**Note:** Highmark requires the Service Facility when the service was performed at a secondary location and the provider’s primary location was sent in the Billing Provider loops.

**Segment:** **N3** **Service Facility Address**

**Loop:** 2310E

**4010 IG Page:** 354

**Note:** When this 2310E Service Facility loop is used, this N3 segment is the address of the location at which the service is performed.

**Segment:** **N4** **Service Facility City/State/Zip Code**

**Loop:** 2310E

**4010 IG Page:** 355

**Note:** When this 2310E Service Facility loop is used, this N4 segment is the city/state/zip of the location at which the service was performed.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| N403 | Postal Code | The 9-digit Zip + 4 Code will result in faster and more accurate processing when the provider did not obtain an NPI for each Highmark legacy ID. |

**Segment:** **SBR** **Other Subscriber Information**

**Loop:** 2320

**4010 IG Page:** 359

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| SBR09 | Claim Filing Indicator Code | When the prior payer is Medicare (Part A, Part B, or Medicare Advantage), use one of the following values:<br><br>16 Health Maintenance Organization (HMO) Medicare Risk<br>MA Medicare Part A<br>MB Medicare Part B |

**Segment:** **NM1** **Other Payer Name**

**Loop:** 2330B

**4010 IG Page:** 411

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM109 | Identification Code | 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.<br><br>Use a unique number that identifies the other payer in the submitter's system. As specified in the national implementation guide, if line level adjudication information from this other payer is being submitted in the 2430 Service Line Adjudication Information loop, it is critical that the Other Payer ID number in this 2330B element match exactly the Payer Identifier in the SVD01 element of the 2430 loop.<br><br>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 within this transaction. |

**Segment:** **LIN** **Drug Identification**

**Loop:** 2410

**4010 IG Page:** Addenda page 35 (not in 4010 IG)

**Note:** Use this segment to report NDC codes that are required for Home Infusion Therapy and drugs that are part of Home Health services.

**Segment:** **CTP** **Drug Pricing**

**Loop:** 2410

**4010 IG Page:** Addenda page 39 (not in 4010 IG)

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| CTP03 | Unit Price | **4010 Non-Addenda** - The CTP segment is not available in the non-addenda standard.<br>**4010A1 Addenda** - Maximum length is 10 characters including reported or implied cents. |

**Segment:** **NM1** **Attending Physician, Operating Physician, and Other Provider Name**

**Loop:** 2420A Attending Physician

2420B Operating Physician

2420C Other Provider

**4010 IG Page:** 465, 472, 479

**Note:** When the Attending Physician, Operating Physician, or Other Provider's National Provider Identifier (NPI) is sent in the 2420A Attending Physician, 2420B Operating Physician, or 2420C Other Provider NM109, Highmark's business processes require the Provider Taxonomy Code, correlating to the contracted specialty be submitted.

# 10 Claim Acknowledgment (277)

The Claim Acknowledgment Transaction is used to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the 837 transaction in batch mode. The 277 Claim Acknowledgment is used within the real-time claim process for certain situations when a real-time 835 response could not be generated. Refer to Section 10.1.6 - Real-time Claim Acknowledgment, for specific information on use of this transaction within the real-time claim adjudication and estimation process. Acceptance at this level is based on 837 Implementation Guide and front-end edits, and will apply to individual claims within an 837 transaction. That is, for a given 837 transaction, this 277 Acknowledgment will indicate which claims were accepted for processing and which claims were not accepted. For those claims not accepted, the 277 will detail additional actions required of the submitter in order to correct and resubmit those claims. Claims that were accepted should not be resubmitted.

Due to the length of the file name, DOS operating systems will not be able to receive 277 Claim Acknowledgment files.

This document applies to acknowledgment transactions from Highmark. The Payer Code is listed for reference:

- Highmark - 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, Highmark Health Insurance Company (HHIC), Gateway Vision, and Independence Blue Cross / Highmark Blue Shield joint products.

Additional Payers

Medi-CareFirst, see Appendix B.

Highmark EDI will accept 837P transactions for the following additional payers. A 277 Claim Acknowledgment produced by the payer will be available from Highmark EDI on the next business day. A link to each payer's companion document is located at:

http://www.ibx.com/providers/self_service_tools/edi/forms.html

- Independence Blue Cross - 54704

- AmeriHealth NJ & DE HMO - 95044
- AmeriHealth NJ & DE non-HMO - 60061 & 93688
- AmeriHealth Administrators - 54763
- Independence Administrators - 54763

# 10.1 General Information and Guidelines for 277 Claim Acknowledgment

## 10.1.1 Identifying the 837 in the 277 Claim Acknowledgment

The 277 Claim Acknowledgment Transaction will contain a reference back to the specific 837 claim transaction that is being acknowledged. The acknowledgment transaction's Reference Identification element (BHT03) will contain the "Originator Application Transaction Identifier" element (BHT03) from the 837 claim transaction. When multiple 837 transactions (ST-SE) are submitted to Highmark in a single Functional Group envelope (GS-GE), one 277 Claim Acknowledgment transaction will be returned acknowledging all the 837 transactions in that Functional Group. The Originator Application Transaction Identifier (BHT03) from the first 837 will be placed in the Reference identification element (BHT03) of the 277 Claim Acknowledgment.

This document applies to acknowledgment transactions from Highmark. The Payer Code is listed for reference:

- Highmark - 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, Clarity and Gateway Vision, and Independence Blue Cross / Highmark Blue Shield joint products.

## 10.1.2 Front-End Editing: Level Types 1-5

DELAYED: Effective November 7, 2008. Highmark will implement a new front-end claim file review process that is designed to increase claim acceptance the first time claims are submitted by Trading Partners. Currently, when an 837 Health Care Claim Professional or Institutional claim file is initially reviewed, if there are Type 1 (X12) or 2 (HIPAA Implementation Guide) syntax errors, the entire transaction

set (ST-SE) is rejected. This is identified by an "R" in the 997 Functional Transactional Acknowledgement AK501 and all claims in that transaction set (ST-SE) must be resubmitted.

Highmark is enhancing its front-end processing for the 997 Functional Acknowledgment to accept with errors, claim files with Type 1 or 2 errors, when they occur in Loops from the 2000A Billing Provider Hierarchical Level to the end of the transaction, except for the SE segment. This will be denoted by an "E - Accepted but Errors Were Noted", in the 997 AK501. The file will continue to process for transactional, not Highmark business, edits Types 3 through 5 (i.e. Balancing, Inter-segment situational, External code sets). At the end of this next review, claims with Types 1 through 5 errors will be separated out of the full file and rejected back to the Trading Partner, using a 277 Claim Acknowledgement (277CA). This means an additional 277CA will be received by a Trading Partner. The first 277CA will identify those claims that were rejected through this new process, following the Highmark 277CA implementation formatting that our Trading Partners are accustomed to receiving. The second 277CA for a partially rejected file will contain those remaining claims not rejected by the new process, indicating which of those claims were forwarded into the adjudication process and which were rejected for front-end business edits (and must be resubmitted). Please note that for Type 1 and 2 errors returned in a 277CA according to this new process, the data will be returned as it was submitted in the original 837 claim.

This new process enables Highmark to continue to process claims without errors through this new step in the process instead of returning the entire file of claims when only one or a few claims have an error. The claims that have been passed along to the business edits review process will be acknowledged on the second 277CA. Both accepted and rejected claims will be identified in this 277CA as occurs today.

### 10.1.3 Text Format Options

For electronic claim submitters using batch mode, that are not able to interpret the 277 Claim Acknowledgment transaction, a text format Claim Acknowledgment report has been developed for Highmark claims (Payer Code 54771). The text format Claim Acknowledgment is NOT available for the real-time claim submission process.

This report can be requested by checking the appropriate box on the EDI Transaction Application form at time of sign-up for HIPAA EDI, or by calling EDI Operations at 800-992-0246. For retrieval of this text format report, see Section 6.1 Command Prompt Options. For best results in printing this report, save the text file in your word processing

format and print from that word processing program with orientation as landscape and font size 8.

## 10.1.4 Timeframe for Batch 277 Claim Acknowledgment

Generally, batch claim submitters should expect a 277 Claim Acknowledgment within twenty-four hours after Highmark receives the 837 claims, subject to processing cutoffs. See section 6.1, Command Prompt Options, for information on retrieving the batch 277 Claim Acknowledgment Transaction.

## 10.1.5 Specifications

The details of Highmark's acknowledgment transaction are contained in the "277 Claim Acknowledgment Reference Guide" on Highmark's EDI website. The following is a link to that document:

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

## 10.1.6 Real-Time Claim Acknowledgment

Effective November 7, 2008, Highmark implemented real-time capability for claim adjudication and claim estimation. The 277 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 837P/I transaction. Acceptance at this level is based on 837P/I Implementation Guides and Highmark's front-end edits. The 277CA will be used to provide status on:

- Claim adjudication and estimation requests (837 P/I) that are rejected as a result of data validation and business data editing (i.e. front-end edits).
- Claim adjudication and estimation requests (837 P/I) accepted through data validation and business editing, but could not be finalized through adjudication/estimation and reported on a real-time 835 response.

### 10.1.6.1 Claim Adjudication

For claims accepted into the system for adjudication, but not finalized through the real-time 835:

- These claims will continue processing in a batch mode and be reported in a daily or weekly batch 'payment cycle 835' when adjudication has been completed.
- The payer assigned claim number will be returned in Loop 2200D/ E - REF of the 277CA. This will allow the provider to track the claim, if necessary.
- The 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.

### 10.1.6.2 Claim Estimation

For estimations accepted into the system, but not finalized through the real-time 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 can not 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 1.2 Real-Time Transaction Capability.

### 10.1.6.3 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 277CA and other acknowledgment responses, such as the SOAP Fault, TA1 and 997. This will enable office staff to understand and correct the relevant transaction information for resubmission, if applicable.

# 11 Claim Payment Advice (835)

The 835 transaction is utilized to send an electronic Explanation of Benefits (EOB) remittance advice from a health care payer to a health care provider. The May 2000 ASC X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the October 2002 Addenda document named in the Modifications to Electronic Data Transaction Standards and Code Sets rule is the primary source for definitions, data usage, and requirements.

Companion documents supplement the national guide and addenda with clarifications and payer-specific usage and content.

Sections 11.1 and 11.2 of this Reference Guide make up the companion document for version 4010A1 835 remittance transactions from Highmark's EDI Operations for patients with Highmark, Federal Employees Health Benefit Plan, Independence Blue Cross (IBC) / Highmark joint products, BlueCard Par Point of Service (POS), Highmark Health Insurance Company (HHIC), Gateway Vision coverage. Highmark (NAIC code 54771) will be designated as the payer for all of these payments except a portion of BlueCard Par POS where IBC (NAIC code 54704) is the payer. See the 837 Payer ID Chart in the Professional Claim section of this guide for details.

Additional Payers

Medi-CareFirst, see Appendix B.

835's will be available for the following payers from Highmark EDI. A link to each payer's companion document is located at:

http://www.ibx.com/providers/self_service_tools/edi/forms.html

- Independence Blue Cross - 54704 (Member ID Alpha Prefix QCA, QCB, QCM)
- AmeriHealth NJ & DE HMO - 95044
- AmeriHealth NJ & DE non-HMO - 60061 & 93688
- AmeriHealth Administrators - 54763
- Independence Administrators - 54763

ISA Segment Specifications - The ISA segment associated with 835 transaction for these payers will follow section 7.3 of this guide with IBC's NAIC code of 54704 in the ISA06 Interchange Sender ID.

GS Segment - IBC's NAIC code of 54704 will be returned in the GS02 Application Sender's Code. The receiver's Highmark assigned Trading Partner Number will be returned in the GS03 Application Receiver's Code.

## 11.1 General Information and Guidelines for 835

While the Claim Payment Advice information listed below may have been submitted in a standard claim transaction, it was not captured and used in processing by the payers listed in the EDI Reference Guide. The payers will utilize data from internal databases.

- Payer name and address
- Payee name and address

### 11.1.1 Missing Checks

If a payment reflected in the 835 is not received, the provider or facility should contact the payer's customer or provider service department for assistance.

### 11.1.2 Administrative Checks

Administrative check information will not be reflected in the 835 transaction. Administrative checks are issued from a manual process and are not part of a weekly or daily payment cycle. A letter or some form of documentation usually accompanies the check. An Administrative check does not routinely contain an Explanation of Benefits notice.

### 11.1.3 Availability of Payment Cycle 835 Transactions (Batch)

Payment 835 transactions are created on a weekly or daily basis to correspond with Highmark's weekly or daily payment cycles. The 835 payment transaction files become available for retrieval after the payment cycle is complete, and remain available for 7 days. If an 835 transaction was expected but not available for retrieval on the third day after the payment cycle was complete, contact EDI Operations for assistance.

Effective November 7, 2008 Highmark will be producing daily payment cycles and 835 transactions in conjunction with real-time claims adjudication. Providers that meet specific real-time claim submission requirements may receive daily payments and 835 transactions for their real-time submitted claims. For additional information or questions on daily payments related to real-time claim submission, providers should contact their Provider Relations representative.

### 11.1.4 Highmark Private Business and Medicare Supplemental

Highmark will produce separate batch or payment 835 transaction files for Private Business Medical-Surgical and Medicare Supplemental products. Additionally, daily 835 files will be produced for those Private Business Medical-Surgical products which currently have a daily payment cycle. All files will utilize Highmark's NAIC code 54771. Providers that receive payments (checks/EFT) for both Private Business products and Medicare Supplemental products must be sure to retrieve all 835 transaction files in any given week.

### 11.1.5 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 reported in the Claim Adjustment Segment at each service line.

### 11.1.6 Highmark Oral Surgery

Claims for oral surgery services that are processed through Highmark Medical-Surgical health care products will be reported in Highmark's 835 transaction.

### 11.1.7 Unavailable Claim Data

Paper claims may not provide all data utilized in the 835. Therefore, some data segments and elements in the 835 Claim Payment Advice may be populated with "dummy data" or not available as a result of the claim submission mode.

## 11.1.8 Claim Overpayment Refunds

### 11.1.8.1 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 offset by the overpayment amount, after any outstanding offsets are applied from previous checks.

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 835. The negative PLB dollars allow the 835 payment to balance and essentially delay or move the refund balance forward to a future 835, when money is available to be offset from a check/EFT.

When the Provider Adjustment PLB segment must be used for amounts to be offset on a future check/EFT, the following codes and information will be used for the PLB segment:

- Adjustment Reason Code WO, Overpayment Recovery, will be used in conjunction with the entire refund amount when Highmark is unable to deduct any of the refund money for a specific claim from the current check/EFT.
- Adjustment Reason Code FB, Forwarding Balance, will be used in conjunction with the remaining (unsatisfied) portion of refund amount when Highmark is able to deduct a portion of the refund money for a specific claim from the current check/EFT.
- The Reference Identification in the PLB segment reflects the claim number from the reversal and correction detail.

When the refund dollars are eventually offset in a subsequent check/EFT, the money is only reflected in the 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 835. The following codes and information will be in a PLB segment used for this purpose:

- Adjustment Reason Code will be either WO or FB, depending on the designation of that money from the prior 835.
- Reference Identifier will reflect the claim number from the previous 835.

### 11.1.8.2 Professional Claims

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

Beginning on January 19, 2007, 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 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 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:

- 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:

- 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 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 835 after the 60 day review period. The following codes and information will be used in the PLB segment used for this purpose:

- 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.

## 11.1.9 Electronic Funds Transfer (EFT)

EFT is the direct deposit of Highmark payments to the provider's bank account. Providers should contact their Provider Relations Representative for more information on EFT eligibility and enrollment.

## 11.1.10 Capitation Payments

Capitation payments will not be combined or reported in the weekly 835 Transaction for fee for service claim payments.

## 11.1.11 Member Identification Numbers

This is the identification number reflected on 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 will not be returned in this transaction.

## 11.1.12 Data that is Not Used

The following segments will not be utilized in the 835:

- CUR - Foreign Currency Information
- REF - Version Identification
- TS3 - Provider Summary Information
- TS2 - Provider Supplemental Summary Information
- QTY - Service Supplemental Quantity

## 11.1.13 National Provider Identifier (NPI)

General information regarding Highmark's NPI project can be found by selecting the 'HIPAA – National Provider Identifier' link from the Provider Resource Center on Highmark's website.

**Highmark does not automatically establish 835 (ERA) relationships for NPI numbers.** An authorization form is required to set up any affiliations between Trading Partners and NPI numbers for the receipt of electronic remittance. The application can be accessed by clicking on the GO TO APPLICATION button on the Claims and Inquiries Sign Up page at:

https://www.highmark.com/edi/signup/claims/index.shtml

Please be advised that for each NPI or billing provider number, Highmark ERA files can be sent to only one recipient (i.e. Trading Partner) number. If an NPI is affiliated with more than one Trading Partner that can receive ERA, the billing provider must identify which one will be the ERA recipient. In instances where professional and institutional providers share an NPI number, the ERA will be generated to a Highmark institutional Trading Partner number. It will not be generated to a professional Trading Partner number.

There are two scenarios for NPI on the 835 as follows:

**Scenario 1: Dual - NPI and Highmark ID**

Payee Identification Segment N1
N103 = XX (Payee's NPI)
N104 = Billing Provider NPI

Payee Additional Identification Segment REF
REF01 = TJ (Payee's Tax Identification Number)
REF02 = Billing Provider Tax ID

AND

REF01 = PQ (Payee Identification)
REF02 = Billing Provider Highmark Provider ID

**Scenario 2: NPI Only**

(Trading partners and Billing Providers must be in agreement regarding NPI only readiness.)

Payee Identification Segment N1
N103 = XX (Payee's NPI)
N104 = Billing Provider NPI

Payee Additional Identification Segment REF
REF01 = TJ (Payee's Tax Identification Number)
REF02 = Billing Provider Tax ID

Please note, that while one 835 transaction (ST-SE) will contain only one of the above scenarios, trading partners may receive multiple transactions (multiple ST-SEs) with any of the above scenarios per interchange (ISA-IEA).

## 11.1.14 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 new option and the specific programs impacted was sent to providers and facilities. Information is also available from your Provider Relations representative.

Highmark will create a separate batch or payment 835 transaction (ST to SE Segment) to document the payment from the member's saving/ spending account. This separate or second 835 reporting methodology is termed a "COB reporting model" meaning the member spending account 835 will have the code value attributes of a secondary claim payment. This is an 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 an 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 835 transaction to document how the remaining liabilities were addressed by the payment from the member's account. The additional 835 transaction, containing members' health care account payments, will have the same structure as the 835 transactions Highmark currently produces. The health care account 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 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: 835 Segments Documenting Payment from Highmark and Payment from the Member's Account**

The example below illustrates the 'COB reporting model' and 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 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) | Highmark Health Care Account Payment (Secondary) |
|---|---|
| N1^PR^HIGHMARK~ | N1^PR^HIGHMARK HEALTH CARE ACCOUNT~ |
| CLP^ABC123^1^200^50^130^12^0123456789~ | CLP^ABC123^2^200^130^^12^0123456789~ |
| NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ | NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ |
| SVC^HC>99245^200^50~ | SVC^HC>99245^200^130~ |
| DTM^150^20060301~ | DTM^150^20060301~ |
| DTM^151^20060304~ | DTM^151^20060304~ |
| CAS^CO^45^20~ | CAS^OA^23^70~ |
| CAS^PR^1^130~ | |

## 11.1.15 Real-Time 835 Response

Effective November 7, 2008, Highmark implemented real-time capability for claim adjudication and claim estimation. A real-time 835 will be used as the response to a real-time claim adjudication or estimation request (837 P/I). The real-time 835 response will contain the finalized results from successful claim adjudication or estimation requests. The real-time 835 response will be based on the ASC X12N 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 1.2 Real-Time Transaction Capability.

### 11.1.15.1 Real-Time Response for Claim Adjudication

The real-time 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 835.

When a member has a health care spending account, also known as a Consumer Spending Account (CSA), and has elected the direct payment to provider option, the real-time 835 response for claim adjudication will indicate the existence of a CSA. Remittance Advice Remark Codes will be used to indicate potential CSA fund availability

and processing. Remittance Advice Remark Codes are reported in the claim level Loop 2100 MIA or MOA Segments or line level Loop 2110 LQ Segment. When applicable, actual payment from a CSA will continue to be generated through a weekly payment cycle and be subsequently reported in the batch or payment CSA 835. See Section 11.1.14 for information on provider payments from member health care accounts.

The following table highlights some of the 835 data elements that have specific relevance to the reporting of real-time adjudicated claims within the 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 835 "payment" amount (BPR02) will equal the claim "paid" amount (CLP04) since this will be a single claim 835. |
| Payment Method | BPR04= NON | Required element - Indicates "Non-Payment Data". This is an informational only 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 835 Response environment. |
| Claim Data | Loops 2000, 2100 & 2110 | The claim data will be reported as adjudicated with appropriate liabilities and provider 'payment' amount. |

### 11.1.15.2 Real-Time 835 Response for Claim Estimation

The real-time 835 response for a real-time claim estimation request will follow the guidelines defined in the ASC X12N 835 Guide, Section 2.2.7 for "Predetermination of Benefits".

The following table highlights some of the 835 data elements that have specific relevance to the reporting of real-time estimation responses within the 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 Amount | BPR02=0 | Required element - An estimation 835 Check Payment Amount will equal 0. |
| Payment Amount | BPR04= NON | Required element - Indicates "Non-Payment Data". This is an informational only 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 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. |

| 835 Data | 835 Element/ Segment | Comments |
|---|---|---|
| Claim/Service Adjustment | CAS | CAS Segment will report all member and provider contractual liabilities.<br><br>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.<br><br>CAS*OA*101*$$$$<br><br>CAS is reported at the applicable Line or Claim level. |

### 11.1.15.3 General Requirements and Best Practices

Trading Partners must have the ability to parse and interpret the information on the 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 835 claim/estimate response be presented on the screen or printed document shown to the member. Some of the provider contractual liabilities and other 835 data reporting on the real-time 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 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 Reference Guides at the following site:

  https://www.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 Blue Shield" Note: All necessary disclaimers for the transaction will be included as one of the Remittance Advice Remark Codes passed in the real-time 835.

Full Accounts Receivable posting should occur from the actual "Payment 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 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 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 835" transaction and a batch cycle "Payment 835" transaction and to process both real-time and batch claims in a single system.

## 11.2 Data Detail for 835

The following segment references are clarifications and payer-specific requirements related to data usage and content.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Highmark will send the NAIC code for the Payer that is sending this transaction:<br>VALUE PAYER<br>54771 Highmark |
| GS03 | Application Receiver's Code | This will be the electronic Trading Partner Number assigned by Highmark's EDI Operations for transmission of 835 Transactions. |
| GS06 | Group Control Number | Highmark will send unique control numbers for each functional group. |

**Segment:** **BPR** **Financial Information**

**Loop:**

**4010 IG Page:** 45-47

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| BPR01 | Transaction Handling Code | The only values that will be passed are H and I.<br><br>NOTE: The real-time 835 response will only use the value H. |
| BPR04 | Payment Method Code | ACH will be utilized when payment is made via electronic funds transfer. This will be applicable to Institutional business only.<br><br>CHK will be utilized when payment is made via check.<br><br>NON will be utilized when the payment amount for the batch (payment cycle) 835 is zero.<br><br>NOTE: The real-time 835 response will always use the value NON. |

**Segment:** **REF** **Receiver Identification**
**Loop:**
**4010 IG Page:** 57

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF02 | Receiver ID | This will be the electronic Trading Partner Number assigned by Highmark's EDI Operations for transmission of 835 Transactions. |

**Segment:** **REF** **Additional Payer Identification**
**Loop:** 1000A
**4010 IG Page:** 68

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF01 | Reference Identification Qualifier | The code value “NF” will be utilized to designate the Payer’s NAIC code in REF02. |
| REF02 | Additional Payer ID | Highmark will send the NAIC code for the Payer that is sending this transaction:<br>VALUE PAYER<br>54771 Highmark |

**Segment:** **N1** **Payee Identification**
**Loop:** 1000B
**4010 IG Page:** 72, 73

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| N103 | Payee Identification Qualifier | FI - will be utilized for the Provider's Tax Identification Number.<br><br>XX - will be utilized for the Provider's National Provider Identifier (NPI). |

**Segment:** **REF** **Payee Additional Identification**
**Loop:** 1000B
**4010 IG Page:** 77, 78

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF01 | Payee Additional Identification Qualifier | TJ - Will be utilized for the Provider's Tax Identification Number when the Provider's NPI is sent in the 1000B Payee Identification N103 and N104. |

## LX Header Number

**Loop:** 2000

**4010 IG Page:** 79

### Data Element Summary

| Ref Des. | Element Name | Element Note |
|---|---|---|
| LX01 | Assigned Number | A number assigned for the purpose of identifying a sorted group of claims. Values:<br>1. All claims except Highmark Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period.<br>2. Highmark Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period. |

## Segment: CLP Claim Payment Information

**Loop:** 2100

**4010 IG Page:** 89

### Data Element Summary

| Ref Des. | Element Name | Element Note |
|---|---|---|
| CLP01 | Claim Submitter's Identifier | The actual Patient Account value may not be passed from paper claim submissions. |
| CLP02 | Claim Status Code | Highmark uses the 'finalized' Claim Status Codes identified in the national implementation guide for adjudicated claims.<br><br>NOTE: Highmark will use the following value for status on a real-time estimation response.<br><br>25 - Predetermination Pricing Only - No Payment |

**Segment:** **NM1** **Service Provider Name**
**Loop:** 2100
**4010 IG Page:** 113

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Service Provider Name Identification Code Qualifier | BS - will be utilized for Blue Plan professional claims.<br>UP - will be utilized for Institutional claims.<br>XX - will be utilized for the Provider's NPI. |

**Segment:** **REF** **Other Claim Related Identification**
**Loop:** 2100
**4010 IG Page:** 126, 127

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF01 | Other Claim Related Information Qualifier | Values 1L, 1W, CE, EA, and G1 will be passed when available or applicable to the claim.<br><br>1W - will be passed on Highmark's Medicare Supplemental 835 to provide the patient's Member ID when the patient is also the Insurance contract holder.<br><br>CE (Professional claims) - This value will be utilized to provide the payer's Class of Contract Code in REF02.<br><br>CE (Highmark Institutional claims) - This value will be utilized to provide the Reimbursement Method Code in REF02. |

**Segment:** **SVC** **Service Payment Information**
**Loop:** 2110
**4010 IG Page:** 141

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| 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:<br>99199 - Unlisted HCPCS Procedure code. (SVC01-1 qualifier is HC)<br>0949 - Unlisted Revenue code. (SVC01-1 qualifier is NU) |

**Segment:** **PLB** **Provider Adjustment**

**Loop:**

**4010 IG Page:** 165-172

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**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PLB01 | Provider Identifier | When the NPI is reported in N104 and a Provider level adjustment applies, the NPI will be reported here also. |
| PLB03-1<br>PLB05-1<br>PLB07-1<br>PLB09-1<br>PLB11-1<br>PLB13-1 | Provider Adjustment Reason Code | Values noted will be passed when applicable for reducing or increasing the provider's check.<br><br>CS - Adjustment<br>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. This code will be effective July 20, 2007.<br><br>FB - Forwarding Balance<br>This value will be used to reflect balance forward refund amounts between weekly 835 transactions. See Section 11.1.8 for more information.<br><br>L6 - Interest Owed<br>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. See Section 11.1.8.2 for information on interest related to deferred refunds.<br><br>WO - Overpayment Recovery<br>This value will be used for recouping claim overpayments and reporting offset dollar amounts. See Section 11.1.8 for more information. |

## Data Element Summary

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PLB03-2<br>PLB05-2<br>PLB07-2<br>PLB09-2<br>PLB11-2<br>PLB13-2 | Provider Adjustment Identifier | Institutional - When the Adjustment Reason Code is "FB" or "WO", the Provider Adjustment Identifier will contain the Highmark Claim Number for the claim associated to this refund recovery.<br><br>Professional - When the Adjustment Reason Code is "FB" or "WO", the Provider Adjustment Identifier will contain the Member's ID and/or a Customer Service Tracking Number. Effective January 19, 2007, 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 835 but the refund amount will not be deducted until after the 60 day appeal period. See section 11.1.8 Claim Overpayment Refunds for more information. |

# 12 Claim Status (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 May 2000 ASC X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the October 2002 Addenda document named in the Modifications to Electronic Data Transaction Standards and Code Sets rule is the primary source for definitions, data usage, and requirements.

Companion documents supplement the national guide and addenda with clarifications and payer-specific usage and content requirements.

Highmark

Sections 12.1 and 12.2 of this Reference Guide make up the companion document for 4010A1 276 and 277 transactions when Highmark is the payer:

- Highmark - 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, Highmark Health Insurance Company (HHIC), Gateway Vision, and Independence Blue Cross/ Highmark Blue Shield joint products.

Independence Blue Cross and Related Payers

Highmark EDI will accept 276 request transactions and return 277 response transactions for the following additional payers. A link to each payer's companion document is located at: http://www.ibx.com/providers/self_service_tools/edi/forms.html

- Independence Blue Cross - 54704
  (Member ID alpha prefix will be QCA, QCB, or QCM; excludes Comp Select.)
- Keystone Health Plan East - 95056
  (Providers in IBC five county service area. Member ID alpha prefix will be YXG or YXH.)
- AmeriHealth Delaware non-HMO - 93688
  (First two characters of Member ID alpha prefix will be Q2)

- AmeriHealth NJ & DE HMO - 95044
- AmeriHealth Administrators - 54763
- Independence Administrators - 54763
  (Providers in IBC five county service area, and Personal Choice Network Providers outside IBC service area)

ISA Segment Instructions - The ISA segment associated with 276 transactions for these payers must follow the guidelines in section 7.2 of this Reference Guide, with Independence Blue Cross's (IBC's) NAIC code of 54704 in the ISA08 Interchange Receiver ID. The ISA segment associated with the 277 response transaction will follow section 7.3 of this guide with IBC's NAIC of 54704 in the ISA06 Interchange Sender ID.

GS Segment Instructions - The submitter's Highmark assigned Trading Partner Number must be placed in the 276 GS02 Application Sender's Code and will be returned in the 277 GS03 Application Receiver's Code. **The payer's** NAIC code must be placed in the 276 GS03 Application Receiver's Code and will be returned in the 277 GS02 Application Sender's Code.

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.

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 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 276 and 277 transactions. Highmark will use the Member ID alpha prefix to identify the need to coordinate with KHP East.

# 12.1 General Instructions and Guidelines for 276 and 277

The sections below will provide guidelines about the 276 and 277 transaction. These sections provide minimum data requirements for submitting a 276 status request, and what data the payer will respond with on the 277 response transaction.

## 12.1.1 General Instructions and Guidelines for 276

The general instruction section will provide guidelines in submitting a successful 276 transaction. Detailed in the sections below are minimum data requirements that must be followed in order for the payer to process the 276 request. Also, there is information on dental services, data not used by the payer, specified minimum data requirements and situational data elements, and limitations on submitting multiple requests.

### 12.1.1.1 General Description

Claim status requests will be processed in real-time or batch mode. Claim status responses for either mode will only include information available on the payers' adjudication system. Claim data which has been purged from the system will not be available on the response. The 276 health care claim request can be used to request a status at a claim level, or for specific service lines.

### 12.1.1.2 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.

### 12.1.1.3 Data that Is Not Used

While the claim status information listed below can be (and in some cases must be) contained in a standard claim status request transaction, this information may not be captured and used by the payers listed in the EDI Reference Guide:

Payer name - NM1 (2100A) - payer will search for claims using the payer ID, not the payer name.

Payer Contact - PER (2100A) - payer will use contact information on internal files when necessary.

Provider name - NM1 (2100C) - payer will search for claims using the billing provider ID, not provider name.

Subscriber name - NM1 (2100D) - payer will search for claims using the member ID or health insurance claim number (HIC#). The subscriber name is not used when the subscriber is not a patient.

Service line information - SVC (2210D/E) - payer will use only the minimum/situational elements described further in this EDI Reference Guide when searching for claims; the payer will not use the service line procedure code information reported in the SVC. Note that the service line information will be returned in the response transaction if the finalized or pended claim is found.

### 12.1.1.4 Minimum Requirements

As specified in the national implementation guide, the following elements and data content must be submitted in order for the payer to begin a claim search:

| | |
|---|---|
| Payer | (2000A) |
| Patient Date of Birth (eff. April 11, 2008) | (2000D/E) |
| Requestor | (2000B) |
| Provider | (2000C) |
| Member ID | (2100D) |
| Service Date | (2200D/E or 2210D/E) |

If the payer's claim number is submitted, the payer will initially limit the search to claims with an exact match to that claim number. If an exact match is not found, a second search will be performed using other

data, such as dates of service or charge amounts, submitted on the claim status request.

### 12.1.1.5 Situational Elements and Data Content

The payer will use the following elements and data content to narrow down the search when looking for claims:

| | |
|---|---|
| Patient Gender | (2000D/E) |
| Patient Last and First Name | (2100D/E) |
| Medical Record Number | (2200D/E) |
| Claim Charge Amount | (2200D/E) |
| Line Item Control Number | (2210D/E) |

If one of these elements eliminates all potential matches, those claims identified prior to that criteria will be returned.

### 12.1.1.6 Requests Per Transaction Mode

The Claim Status process for the payers in this Reference Guide is limited to one Information Source, Information Receiver and Provider per ST - SE transaction.

- Batch mode - if multiple requests are sent, only the first occurrence within each loop will be processed.
- Real-time mode - if multiple requests are sent, the transaction will be rejected.

**Batch Requests**

Multiple subscribers for one provider and/or multiple dependents for one subscriber can be submitted and a response will be sent for each. Requests for both the subscriber and that subscriber's dependent cannot be included in the same subscriber loop; rather, there must be one subscriber loop for the request concerning the subscriber and a second subscriber loop for the request concerning the dependent.

**Real-Time Requests**

Only one patient and corresponding claim status request can be submitted and a response to that single request will be returned. One patient is defined as either, one subscriber loop with the claim status request, when the subscriber is the patient, or one dependent loop with

the claim status request, when the dependent is the patient. For the dependent patient scenario, the subscriber identification loop must also be sent and returned to meet transaction structure requirements.

NOTE: Effective October 31, 2005, all Blue Plans will have real-time capability. In the interim, if Highmark receives a real-time request for a patient who has coverage with a Plan that has not implemented real-time capability, the following rejection response will be returned in the 277 response transaction:

Loop 2200D/E STC01-1 = E1 (response not possible - system status)

Loop 2200D/E STC01-2 = 494 (real-time requests not supported by information holder; resubmit as a batch request)

#### 12.1.1.7 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.

### 12.1.2 General Instructions and Guidelines for 277

The general instruction section will provide information regarding a 277 transaction. Detailed in the sections below is the data that will be sent on a 277 response by the payer. This section also addresses claim splits, when to call customer service and the maximum claims returned for one 276 claim status request.

#### 12.1.2.1 General Description of 277

The 277 health care claim response will contain information for both pending and finalized claims. Service line information will be returned for both types of claims. All claim service lines will be returned on a 277 response to a 276 request that indicated specific service lines.

### 12.1.2.2 Claim Splits

Claims split during processing will be reported as multiple claims on the 277 Claim Status Response, when a Payer Claim Identification Number (2200D/E REF) was not submitted on the 276 Request. When a Payer Claim Identification 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 Indentification Number.

### 12.1.2.3 Customer Service Requests

When it is determined that a request cannot be answered from the information provided, please change your search criteria or contact the customer service area (according to normal procedures).

### 12.1.2.4 Maximum Claim Responses per Subscriber/Patient/ Dependent

If multiple claims are found for one status request, the payer will only 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.

### 12.1.2.5 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.

### 12.1.2.6 National Provider Identifier

Providers that enumerate their current Highmark provider identifiers in a one-to-one relationship with an NPI will encounter no changes to the claims returned on claim status inquiry responses. Providers that obtain only one NPI that matches to multiple Highmark IDs, may receive more data back if the services the patient received were on the same date and were rendered by multiple Legacy Billing Providers that now use the same NPI.

# 12.2 Data Detail for 276

The following pages contain clarifications and payer-specific requirements for data usage and content. Minimum data requirements listed must be followed in order for the payer to process the 276 claim status request transaction.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Use the sender's Highmark-assigned Trading Partner Number, with a prefix of B or R as follows:<br>B = requesting batch mode response.<br>R = requesting real-time response.<br><br>The submitted value must not include leading zero's. |
| GS03 | Application Receiver's Code | To support Highmark's routing process, all 276 transactions in a functional group should be for the same payer. Submit the NAIC number for the payer identified in loop 2100A of the 276 transaction. Following is a list of recognized payers and their respective NAIC codes:<br><br>54771 - Highmark |
| GS06 | Group Control Number | Highmark does not have specific requirements for this element. |

**Segment:** **NM1** **Payer Name**
**Loop:** 2100A
**4010 IG Page:** 55, 56

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | The payers' Claim Status routing process requires the use of the National Association of Insurance Commissioners (NAIC) Identification, therefore code value "NI" must be used with the appropriate NAIC identifier in NM109. |
| NM109 | Payer Identifier | Enter the payer's NAIC number from the list below. This must be the same number as identified in GS03. All 276 transactions for a functional group must be for the same payer.<br><br>54771 - Highmark |

**Segment:** **NM1** **Information Receiver Name**

**Loop:** 2100B

**4010 IG Page:** 63

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | The payers' Claim Status process requires the use of the Trading Partner Number as assigned by Highmark EDI Operations. This must be designated by a code value in this data element of "46", Electronic Transmitter Identification Number. |
| NM109 | Information Receiver Identification Number | Send Trading Partner Number as assigned by Highmark's EDI Operations. This must be the same number as identified in GS02. Multiple Information Receivers require multiple Functional Groups. The submitted value must not include leading zero's. |

**Segment:** **NM1** **Provider Name**

**Loop:** 2100C

**4010 IG Page:** 68, 69

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | Send the provider's National Provider Identifier (NPI). Place qualifier XX in NM108 and the actual identifier in NM109 |

**Segment:** **NM1** **Subscriber Name**
**Loop:** 2100D
**4010 IG Page:** 75, 76

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | Use code value "MI", Member Identification Number. |
| 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. |

**Segment:** **REF** **Payer Claim ID Number**
**Loop:** 2200D
2200E
**4010 IG Page:** 79

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF02 | Payer Claim Identification Number | Enter the Payer's Claim Control Number.<br><br>Note1 - this is not the Patient Account Number.<br>Note2 - 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. |

# 12.3 Data Detail for Claim Status Response (277)

The following segment references are clarifications and payer-specific data usage and content in the response transaction.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Senders' Code | Highmark will send the NAIC code for the Payer that is sending this response:<br>VALUE PAYER<br>54771 Highmark |
| GS03 | Application Receiver's Code | The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix of B or R as follows:<br>B = batch mode response was requested.<br>R = real-time response was requested.. |
| GS06 | Group Control Number | Highmark will send unique control numbers for each functional group. |

# NM1 Provider Name

**Loop:** 2100C

**4010 IG Page:** 143

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | The type of Provider ID in this segment will be the same provider type as was submitted in the 276 request. |

**Segment:** **REF** **Payer Claim Identification Number**

**Loop:** 2200E

**4010 IG Page:** 210

**Note:** The national 277 Implementation Guide erroneously requires this REF segment on all 277 responses when the response is related to a dependent. In those cases where a payer claim number was not included in the 276 request, or a claim is not identified by the search criteria, there will not be a valid claim number to include in the response. In such a case, a default value of the word "UNAVAILABLE" will be sent for Highmark members to satisfy the syntax requirement for this segment. The default value returned may vary among Blue Cross Blue Shield Plans, therefore if the patient has coverage with another Plan, other default values may be returned. The usage requirement for this REF segment will be corrected to Situational in a future version of the Implementation Guide.

Also, note #1 for this segment in the implementation guide is wrong. It states: "Use this only if the subscriber is the patient." It should state just the opposite: "Use this only if the patient is someone other than the subscriber." Highmark's 277 transaction will send this Payer Claim Number segment if the Claim Number is known and the patient is other than the subscriber.

# 13 Eligibility Request-270 / Response-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 2000 ASC X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the October 2002 Addenda document named in the Modifications to Electronic Data Transaction Standards and Code Sets rule is the primary source for definitions, data usage, and requirements.

Companion documents supplement the national guide and addenda with clarifications and payer-specific usage and content requirements.

Highmark

Sections 13.1 and 13.2 of this Reference Guide make up the companion document for 4010A1 270 and 271 transactions when Highmark is the payer:

- Highmark - 54771
  (includes Independence Blue Cross/Highmark Blue Shield Comp Select, Highmark Indemnity, Preferred Provider Organization PPO, Point of Service POS, Health Maintenance Organization HMO, Comprehensive Major Medical CMM, Major Medical, Medicare Supplemental, and Highmark Health Insurance Company [HHIC])

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.

# 13.1 General Instructions and Guidelines for 270 and 271

## 13.1.1 Highmark Requirements

In some instances Highmark's business is supported by only some of the allowed values. In these cases the values allowed are identified in the reference guide along with the action which will be taken if the guide is not followed.

## 13.1.2 Dental and Oral Surgery Inquiries

All Dental inquiries must be submitted as a separate transaction set and follow UCCI standards. Oral Surgery inquiries must be submitted to both Highmark for Medical coverage and UCCI for Dental coverage.

## 13.1.3 Definition of Active Coverage

“Active” is defined as coverage where the effective date is less than or equal to date of service and the cancel date is null or is greater than or equal to the date of service. 'Inactive' is coverage where the cancel date is less than or equal to the date of service.

## 13.1.4 Benefit Inquiries

For all Service Type Codes (EQ01), Highmark will provide the following benefit provisions that are applicable to that service type:

- Active or inactive coverage
- Plan coverage description
- Coverage level code
- Co-pay amount
- Deductible amount
- In / out of network indicator
- Time period qualifier
- Benefit amount
- Benefit percent

- Quantity qualifier
- Benefit quantity
- Authorization or certification indicator
- Co-insurance amount
- Out of pocket (stop loss)
- Pre-existing condition indicator

Highmark will also provide general benefit information for Patient Responsibility, Copay, Coinsurance, and Deductible for both In-Network and Out-of-Network for the following: Physician (PCP) Office Visit, Physician (Specialist) Office Visit, Hospital Inpatient, and Hospital Outpatient, when applicable to the patient's benefits. Highmark also provides the remaining balances for the deductible, copay and out of pocket benefits.

## 13.1.5 Allowable Time Frames for Inquiries

Highmark will respond to requests up to 24 months prior to the current date, and will respond with current coverage if the requested date up to 6 months in the future.

## 13.1.6 Disclaimers

Enrollment information may change due to cancellations or other changes in coverage. Highmark acknowledges and understands that the information contained in a 271 response reflects current files. Claims will be processed according to benefit and membership information on our files at the time of processing. Therefore, the information contained within a 271 response does not guarantee reimbursement.

Accumulators are current as of the date of the request.

## 13.1.7 Dates on the Incoming 270

When dates are submitted at both the Subscriber/Dependent level and the Eligibility/Inquiry level, the date at the Eligibility/Inquiry level will take precedence.

## 13.1.8 Range Dates on the Incoming 270

When a range date is submitted, we will use the first date of the range.

## 13.1.9 Level of Detail on Outbound 271

Highmark will provide a response at the (EQ01) service type level only.

## 13.1.10 Specific Service Code Request

Highmark will accept all Service Type Code requests; however, the following Service Type Codes will be converted to a Service Type Code "01" (Medical Care) for response:

85 - AIDS
87 - Cancer
AA - Rehabilitation (Room and Board)
BA - Independent Medical Examination
BJ - Skin
BK - Orthopedic
BL - Cardiac
BM - Lymphatic
BN - Gastrointestinal
BP - Endocrine
BQ - Neurology
BR - Eye

## 13.1.11 Generic Service Code Request

Based on requirements by the Blue Cross Blue Shield Association, all 270 requests containing an EQ01 of “30” (Health Benefit Plan Coverage), will receive a 271 response that includes EB segments with these EB03 values, if applicable 30, 48, 50, 52, 98, A7 and A8.

## 13.1.12 Real-Time Request

Effective April 18, 2005, eligibility requests will be processed in either real-time or batch mode.

## 13.1.13 (Left blank intentionally.)

## 13.1.14 Data that is Not Used

While the eligibility information listed below can be (and in some instances must be) contained in a standard eligibility transaction, this

information will not be captured and used in processing by the payers listed in this EDI Reference Guide:

- Information Receiver Additional Identification - REF (2100B) - payer will use the primary identifier in the NM1.
- Information Receiver Address - N3, N4 (2100B) - payer does not need for processing.
- Information Receiver Contact Information - PER (2100B) - payer will use information on internal files when a contact is necessary.
- Patient Address - N3, N4 (2100C & 2100D) - payer does not need for processing.

## 13.1.15 Requests Per Transaction Mode

The Eligibility Inquiry process for the payers in this Reference Guide is limited to one Information Source, and Information Receiver per ST - SE transaction.

- Batch mode - if multiple requests are sent, only the first occurrence within each loop will be processed.
- Real-time mode - if multiple requests are sent, the transaction will be rejected.

**Batch Requests**

Multiple subscribers and multiple dependents for a single subscriber can be submitted and a response will be sent for each. Requests for both the subscriber and that subscriber's dependent cannot be included in the same subscriber loop; rather, there must be one subscriber loop for the request concerning the subscriber and a second subscriber loop for the request concerning the dependent.

**Real-Time Requests**

Only one patient and corresponding eligibility request can be submitted and a response to that single request will be returned. One patient is defined as either, one subscriber loop with the eligibility request, when the subscriber is the patient, or one dependent loop with the eligibility request, when the dependent is the patient. For the dependent patient scenario, the subscriber identification loop must also be sent and returned to meet transaction structure requirements.

## 13.1.16 Date Ranges Submitted on the 270

Dates can be submitted at several levels with the 270 request. Processing will be conducted in the following order:

- If the Eligibility Question (EQ) level has a date, that will be used for processing the request.
- If no date at the EQ level, a patient level date will be used.
- If no date at either the EQ or patient level, the transaction creation date (BHT04) will be used.

If the patient level date is used, and multiple type dates are submitted at that level, the payer will determine the priority of dates for processing based on the type of requestor:

- For a professional provider question, the sequence is Service (DTP01 qualifier 472), Admission (DTP01 qualifier 435), then Eligibility (DTP01 qualifier 307).
- For a hospital / facility question, the sequence is Admission, Service, then Eligibility.
- For a payer question, the sequence is Eligibility, Service, then Admission.

## 13.1.17 Minimum Amount of Data Required for Search

Including the following four pieces of patient data on the incoming 270 will result in the best chance of a match to the payer's eligibility file:

- Member ID
- Date of Birth
- First Name
- Last Name

## 13.1.18 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 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.

## 13.2 270/271 Data Detail Instructions

This section will provide the data detail that is required when submitting a 270 transaction. The segments below contain the minimum data requirements that must be followed in order for the payer (Information Source) to process the 270 eligibility request transaction. This section also covers what data detail will be sent by the payer on a 271 response transaction.

### 13.2.1 Data Detail for Eligibility Request (270)

This section includes specific comments and directions for Highmark’s implementation of the 270 transaction. Please read them carefully.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Use the sender's Highmark-assigned Trading Partner Number, with a prefix of B or R as follows:<br>B = requesting batch mode response.<br>R = requesting real-time response.<br><br>The submitted value must not include leading zero's. |
| GS03 | Application Receiver's Code | Submit the Receiver's NAIC code value:<br><br>54771 - Highmark |
| GS06 | Group Control Number | Highmark does not have specific requirements for this element. |

**Segment:** **BHT** **Beginning of Hierarchical Transaction**

**Loop:**

**4010 IG Page:** 38

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| BHT02 | Transaction Set Purpose Code | Use value “13”, Request. Values “01” and “36” apply to Medicaid and therefore are not applicable to Highmark products. |
| BHT06 | Transaction Type Code | This data element applies to Medicaid and should not be used for Highmark products. |

**Segment:** **NM1** **Information Source Name**

**Loop:** 2100A

**4010 IG Page:** 44

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM101 | Entity Identifier Code | Enter code value “PR”, Payer |
| NM102 | Entity Type Qualifier | Enter code value “2”, Non-person entity |
| NM103 | Name Last or Organization Name | Highmark does not require this element. |
| NM108 | Identification Code Qualifier | Enter code value “NI”, NAIC Identification |
| NM109 | Information Source Primary Identifier | Enter NAIC code value:<br><br>54771 - Highmark |

**Segment:** **NM1** **Information Receiver Name**
**Loop:** 2100B
**4010 IG Page:** 47

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM101 | Entity Identifier Code | Highmark business practices do not allow for eligibility inquiries from Third Party Administrators, Employers or Plan Sponsors. |
| NM108 | Identification Code Qualifier | Enter code value 'XX' for NPI on a provider request or “PI” for NAIC number on a payer request. |

**Segment:** **NM1** **Subscriber/Dependent Name**
**Loop:** 2100C
2100D
**4010 IG Page:** 71/114

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | Enter code value “MI”<br>Member Identification Number. |
| NM109 | Identification Code | Enter the full Unique Member ID (Highmark) or Unique Subscriber ID (IBC) including the alpha prefix found on the patient's healthcare ID card. |

**Segment:** **REF** **Subscriber/Dependent Additional Identification**

**Loop:** 2100C

2100D

**4010 IG Page:** 54

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| REF01 | Reference Identification Qualifier | If group number (6P), HIC number (F6), or Social Security Number (SY) are known, they should be used to help Highmark identify the patient.<br><br>Do not use special characters such as dashes or spaces that may appear on the patient's health care ID card. |

**Segment:** **PRV** **Provider Information**

**Loop:** 2100C

**4010 IG Page:** 82

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PRV02 | Reference Identifier Qualifier | Only acceptable qualifier is 9K, Servicer. |

**Segment:** **EQ Subscriber/Dependent Eligibility or Benefit Inquiry Information**

**Loop:** 2110C

2110D

**4010 IG Page:** 90

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| EQ02 | Composite Medical Procedure Identifier | Highmark's business practice does not respond to eligibility benefits at this level, if present we will respond as with a generic EQ01, "01". |
| EQ03 | Coverage Level Code | Highmark will not use this code. We will respond based on information on our Database. |
| EQ04 | Insurance Type Code | Highmark will not use this code. |

**Segment:** **III Subscriber/Dependent Eligibility or Benefit Inquiry Information**

**Loop:** 2115C

2115D

**4010 IG Page:** 101

**Note:** Highmark does not consider the information in the III segment of an incoming 270 Eligibility Request. If a place of service indicates different benefits, a III segment at the EB level will be sent on the 271.

## 13.2.2 Data Detail for Eligibility Response (271)

This section includes specific comments and directions for Highmark's implementation of the 271 transaction. Please read them carefully.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | The sender's NAIC code for the Payer that is sending this response:<br>VALUE PAYER<br>54771 Highmark |
| GS03 | Application Receiver's Code | The receiver's Highmark-assigned Trading Partner Number will be used, with a prefix of B or R as follows:<br>B = batch mode response was requested.<br>R = real-time response was requested. |
| GS06 | Group Control Number | Highmark will send unique control numbers for each functional group. |

# NM1 Information Receiver Name

**Loop:** 2100B

**4010 IG Page:** 178

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | The type of ID in this segment will be the same type as was submitted in the 270 request. |

# Segment: NM1 Subscriber/Dependent Name

**Loop:** 2100C

2100D

**4010 IG Page:** 193 / 271

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | "MI" Member Identification Number |
| NM109 | Identification Code | 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. |

**Segment:** **N3** **Subscriber/Dependent Address**

**Loop:** 2100C

2100D

**4010 IG Page:** 200

**Note:** Highmark business practice does not supply Subscriber/Dependent address information for eligibility inquiries.

**Segment:** **N4** **Subscriber/Dependent City, Street, Zip Code**

**Loop:** 2100C

2100D

**4010 IG Page:** 201

**Note:** Highmark business practice does not supply Subscriber/Dependent address information for eligibility inquiries.

**Segment:** **DTP** **Subscriber/Dependent Date**

**Loop:** 2100C

2100D

**4010 IG Page:** 216, 293

**Note:** Date that is applicable to all Subscriber/Dependent Eligibility or Benefit Information (2110C/2110D) loops that are within this Subscriber/Dependent Name (2100C / 2100D) loop. Type of date is indicated by Date Time qualifier code in DTP01 data element.

**Segment:** **REF** **Subscriber/Dependent Additional Information**

**Loop:** 2110C

2110D

**4010 IG Page:** 238, 315

**Note:** Highmark will return the group number associated with each benefit at the benefit level in addition to returning it at the Patient level.

**Segment:** **DTP** **Subscriber/Dependent Eligibility/Benefit Date**

**Loop:** 2110C

2110D

**4010 IG Page:** 240, 317

**Note:** Highmark will return a coordination of benefits date, if the information is available with applicable effective/cancel/certification information.

Highmark will return an effective/termination date range for any service code that has a different effective/termination date than that reported at the 2100 C/D level.

**Segment:** **MSG** **Message Text**

**Loop:** 2110C

2110D

**4010 IG Page:** 244, 321

**Note:** Benefit co-pay provisions that apply explicitly and only to Urgent Care or Specialist Office Visits will be designated by narrative text in this segment of "URGENT" or "SPECIALIST". Specific code values for

these focused co-pays are added in the next version of the national standard.

# 14 Health Care Services Review (278)—Request and Response

The 278 Services Review Request is utilized by providers and facilities to request reviews for specialty care and admissions. The 278 Services Review Response is utilized by Utilization Management Organizations (UMOs) to respond with results from reviews for specialty care and admission. The May 2000 ASC X12N Implementation Guide named in the HIPAA Administrative Simplification Electronic Transaction rule as modified by the October 2002 Addenda document named in the Modifications to Electronic Data Transaction Standards and Code Sets rule is the primary source for definitions, data usage, and requirements.

Highmark

Sections 14.1 and 14.2 of this Reference Guide make up the companion document for 4010A1 278 transactions when Highmark is the UMO:

- Highmark - 54771
  (includes Independence Blue Cross/Highmark Blue Shield Comp Select, Highmark Indemnity, Preferred Provider Organization PPO, Point of Service POS, Health Maintenance Organization HMO, Comprehensive Major Medical CMM, Major Medical, Medicare Supplemental, and Clarity Vision)

## 14.1 General Information and Guidelines for Submitting a 278

Highmark will accept requests in either batch or real-time. Two connection modes are supported for real-time submission.

Highmark's EDI area supports two modes of connection, asynchronous and FTP. If the submitter utilizes an FTP connection, the real-time request will be responded to within 10 minutes. If the submitter connects to Highmark via an asynchronous connection, real-time requests will be responded to within one minute.

### 14.1.1 Real-Time Requests

Health Care Services Review requests will be processed in either real-time or batch mode.

### 14.1.2 Data that is Not Used

While the authorization information listed below can be (and in some instances, must be) contained in a standard request transaction, Highmark's processing does not currently use the following information:

1. Provider Role and Specialty Information
2. Subscriber/Dependent Supplemental Identification
3. Dependent Relationship

### 14.1.3 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 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 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 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.

## 14.2 Data Detail Instructions

This section includes specific comments and directions for Highmark's implementation of the 278 transaction. Please read them carefully.

## 14.2.1 Data Detail for Services Review Request (278)

The following segment references are clarifications and payer-specific requirements related to data usage and content.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Use the sender's Highmark-assigned Trading Partner Number, with a prefix of R or B:<br>R = requesting real-time response<br>B = requesting batch mode response<br>The submitted value must not include leading zero's. |
| 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. Highmark's NAIC Code is 54771. |
| GS06 | Group Control Number | Highmark does not have specific requirements for this element. |

**Segment:** **NM1** **Utilization Management Organization (UMO) Name**

**Loop:** 2010A

**4010 IG Page:** 55

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM108 | Identification Code Qualifier | Enter code value "PI" - Payor Identification. |
| NM109 | Identification Code | 54771 (Highmark NAIC Code) |

**Segment:** **N3** **Requester Address**

**Loop:** 2010B

**4010 IG Page:** 65

**Note:** 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.

**Segment:** **N4** **Requester City/State/Zip Code**

**Loop:** 2010B

**4010 IG Page:** 66

**Note:** 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.

**Segment:** **PER** **Requester Contact Information**

**Loop:** 2010B

**4010 IG Page:** 68

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PER02 | Name | Due to Highmark's business practices, this information is needed to process authorizations. |
| PER03 | Communication Number Qualifier | Enter code value "TE" - Telephone. |
| PER04 | Communication Number | Always include an area code with the telephone number. |

**Segment:** **HI** **Subscriber/Dependent Diagnosis**

**Loop:** 2000C

2000D

**4010 IG Page:** 80, 103

**Note:** Due to Highmark's business practices, at least one patient diagnosis is needed to process authorizations.

**Segment:** **PWK** **Additional Patient Information**

**Loop:** 2000C

2000D

2000F

**4010 IG Page:** Addenda pages 42, 56, 105 (not in 4010 IG)

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| PWK02 | Attachment Transmission Code | Due to Highmark's business systems, values "AA", "BM", and "FX" are the only methods by which additional information can be received. |

**Segment:** **NM1** **Subscriber/Dependent Name**

**Loop:** 2010C

2010D

**4010 IG Page:** 89, 112

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| NM103 | Subscriber/ Dependent Last Name | Due to Highmark's business practices, this information is needed to process authorizations. |
| NM104 | Subscriber/ Dependent First Name | Due to Highmark's business practices, this information is needed to process authorizations. |
| NM105 | Subscriber/ Dependent Middle Name | Due to Highmark's business practices, in instances of multiple births, this information will expedite the authorization request. |

**Segment:** **DMG** **Subscriber/Dependent Demographic Information**

**Loop:** 2010C

2010D

**4010 IG Page:** 94, 116

**Note:** Due to Highmark's business practices, this information is needed to process authorizations.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| DMG02 | Subscriber Birthdate | The subscriber's birthdate is needed in 2010C when the subscriber is the patient. |
| DMG02 | Dependent Birthdate | The dependent's birthdate is needed in 2010D when the dependent is the patient. |

**Segment:** **HL** **Service Provider Level**

**Loop:** 2000E

**4010 IG Page:** 121

**Note1:** Due to Highmark's business practices, for Facility requests, the Service Provider Loop along with one iteration of the 2010E Service Provider Name Loop is needed to process authorization requests.

**Note2:** Due to Highmark's business practices, for Professional requests, the Service Provider Loop along with two iterations of the 2010E Service Provider Name Loop containing the Group, followed by the Practitioner (in a second iteration of the 2010E Loop), are needed to process authorization requests.

**Segment:** **N3** **Service Provider Address**

**Loop:** 2010E

**4010 IG Page:** 129

**Note:** Due to Highmark's business practices, this information is needed to identify the Service Provider, Practice, Supplier, or Institution location.

**Segment:** **N4** **Service Provider City/State/Zip Code**

**Loop:** 2010E

**4010 IG Page:** 130

**Note:** Due to Highmark's business practices, this information is needed to identify the Service Provider, Practice, Supplier, or Institution location.

**Segment:** **PER** **Service Provider Contact Information**

**Loop:** 2010E

**4010 IG Page:** 132

**Note:** Due to Highmark's business practices, this information is needed to process authorizations.

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| 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 inquires, there must be a value in PER04 so Highmark can contact the provider. |
| PER03 | Communication Number Qualifier | Enter code value "TE" - Telephone. |
| PER04 | Communication Number | Always include an area code with the telephone number. |

**Segment:** **UM** **Health Care Services Review Information**

**Loop:** 2000F

**4010 IG Page:** 141

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| UM03 | Service Type Code | Due to Highmark's business practices, this information is needed to process authorizations. |
| UM04 | Health Care Service Location Information | Due to Highmark's business practices, this information is needed to process authorizations. |
| UM04-2 | Facility Code Qualifier | Enter code value "B", Place of Service code from the Centers for Medicare & Medicaid Services. |
| UM06 | Level of Service Code | Required for request to be considered "Urgent." Enter one of the following values:<br>03 - Emergency<br>U - Urgent. |

**Segment:** **HI** **Procedures**

**Loop:** 2000F

**4010 IG Page:** 159

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| HI01-1<br>HI02-1<br>HI03-1<br>HI04-1<br>HI05-1<br>HI06-1<br>HI07-1<br>HI08-1<br>HI09-1<br>HI10-1<br>HI11-1<br>HI12-1 | Code List Qualifier Code | Enter code value “BO” - Health Care Financing Administration Common Procedural Coding System. |
| HI01-4<br>HI02-4<br>HI03-4<br>HI04-4<br>HI05-4<br>HI06-4<br>HI07-4<br>HI08-4<br>HI09-4<br>HI10-4<br>HI11-4<br>HI12-4 | Date Time Period | Due to Highmark’s business practices, this information is needed to process authorizations. Enter the proposed or actual date of the procedure. |

## 14.2.2 Data Detail for Services Review Response (278)

The following Segment references are clarifications and payer-specific requirements related to data usage and content.

**Segment:** **GS** **Functional Group Header**

**Loop:**

**4010 IG Page:** B.8

**Data Element Summary**

| Ref Des. | Element Name | Element Note |
|---|---|---|
| GS02 | Application Sender's Code | Highmark will send the NAIC code for the Utilization Management Organization (UMO) that is sending this response:<br>VALUE PAYER<br>54771 Highmark |
| GS03 | Application Receiver's Code | Highmark's Trading Partner Number assigned to the receiver will be used, with a prefix of R or B:<br>R = real-time response was requested,<br>B = batch mode response was requested. |
| GS06 | Group Control Number | Highmark will send unique control numbers for each functional group. |

# Appendix A Highmark Health Insurance Company

Mountain State providers submitting transactions for Highmark Health Insurance Company (HHIC) members should refer to the Mountain State Blue Cross Blue Shield's Provider EDI Guide (https://www.msbcbs.com/PDFFiles/Provider-EDI-Guide.pdf) for instructions.

# Appendix B Medi-CareFirst BlueCross BlueShield

Highmark EDI will accept/send the following transactions for Medi-CareFirst BlueCross BlueShield (Medi-CareFirst):

- Professional Claims (837P)
- Institutional Claims (837I)
- Functional Acknowledgment (997)
- Claim Acknowledgment (277CA)
- Claim Payment Advice (835)

Medi-CareFirst members can be identified by their Member Indentificaton Cards.

Guidelines for Medi-CareFirst transactions and EDI envelopes are identical to guidelines for Highmark EDI with the following exceptions:

1. Trading Partner ID

   In order to conduct Medi-CareFirst transactions, Trading Partners must obtain a unique Medi-CareFirst Trading Partner ID, and use that ID in all transactions and envelopes in place of their Highmark Training Partner ID. Authorization forms will be available online to obtain a Medi-CareFirst Trading Partner ID.

   For envelopes and transactions being sent to Highmark, the Medi-CareFirst Trading Partner ID must be used in:

   - GS Functional Group Header - GS02 Application Sender's Code
   - 837P Professional Claim - Loop 1000A NM109 Submitter Identifier
   - 837I Institutional Claim - Look 1000A NM109 Submitter Identifier

   For envelopes and transactions being sent by Highmark, the Medi-CareFirst Trading Partner ID will be placed in:

   - GS Functional Group Header - GS03 Application Receiver's Code
   - 277 Claim Acknowledgement - Loop 2000B NM109 Information Receiver ID

- 835 Claim Remittance - Transaction Header REF02 Receiver ID

2. Logon ID

   At the completion of the Authorization Process for a Medi-CareFirst Trading Partner, a Logon ID and Password will be assigned. The Logon ID is used as follows:

   - ISA Interchange Control Header to Highmark - ISA06 Interchange Sender ID
   - ISA Interchange Control Header sent by Highmark - ISA08 Interchange Receiver ID

3. Medi-CareFirst Receiver/Sender/Payer ID

   For envelopes and transactions being sent to Highmark, Medi-CareFirst's NAIC number 19100, must be used in:

   - ISA Interchange Control Header – ISA08 Interchange Receiver ID
   - GS Functional Group Header – GS03 Application Receiver's Code
   - 837P Professional Claim – Loop 1000B NM109 Receiver Primary ID, and Loop 2010BB NM109 Payer ID
   - 837I Institutional Claim – Loop 1000B NM109 Receiver Primary ID, and Loop 2010 BC NM109 Payer ID

   For envelopes and transactions being sent by Highmark, Medi-CareFirst's NAIC number, 19100, will be placed in:

   - ISA Interchange Control Header – ISA06 Interchange Sender ID
   - GS Functional Group Header – GS02 Application Sender's Code
   - 277 Claim Acknowledgment – Loop 2100 NM109 Payer ID
   - 835 Claim Payment Advice – Loop 1000A REF02 Additional Payer ID

# Appendix C Provider Guide Changes for April 5, 2010

The items below were revised from the November 2, 2009 version to this April 5, 2010 version of the Provider EDI Reference Guide. Revisions are marked in the body of the guide by a vertical line on the side of the page next to the change.

| Page | Segment/ Section | Transactions | Description |
|---|---|---|---|
| Numerous Pages | Numerous Pages | All | Transactions for Pennsylvania HHIC members follow Highmark instructions. Mountain State providers referred to MSBCBS Provider EDI Guide. |
| 76 | 2400 SV103 | 837P | After April 16th, moderate sedation is reported with units, not minutes. |
| 131 | 1000A REF | 835 | 54704 Independence Blue Cross removed as possible value. |