

Provider EDI Reference Guide

Highmark West Virginia

EDI Operations Feb 1, 2011

*****This page left blank intentionally*****

Table of Contents

Chapter 1 • Introduction	13
1.1 Supported EDI Transactions.	14
1.2 Real-Time Transaction Capability.	15
1.2.1 Real-Time Technical Connectivity Specifications.	15
1.2.2 Real-Time Claim Adjudication and Estimation	16
1.2.2.1 General Requirements and Best Practices	16
Chapter 2 • General Information	17
2 Contact Information	17
2.1 System Operating Hours.	18
2.2 Provider Data Services	18
2.3 Audit Procedures	18
2.4 Valid Characters in Text Data (AN, string data element type) . . .	19
Chapter 3 • Security Features	19
3.1 Confidentiality	20
3.2 Authorized Release of Information	20
Chapter 4 • Authorization Process	20
4.1 Where to Get Enrollment Forms to Request a Trading Partner ID21	
4.2 Receiving 835 Transactions Generated from the Payment Cycle (Batch).	21
4.3 Adding/Deleting Providers to an Existing Trading Partner.	21
4.4 Reporting Changes in Status	22

February 1, 2011

4.5 Out of State Providers.	22
Chapter 5 • Testing Policy	23
5.1 Web Based	23
5.2 Highmark West Virginia Transactional Testing	24
5.2.1 Real-Time 837 Claim Estimation Demonstration Process	25
Chapter 6 • Communications	26
6.1 Dial-Up / Asynchronous File Transfer.	26
6.1.1 Dial-Up Command Prompt Option	26
6.2 Internet	27
6.2.1 Internet File Transfer Protocol (FTP) through “eDelivery”	27
6.2.2 Internet/Real-Time (HTTPS- Hypertext Terminal Protocol Secure)	29
Chapter 7 • Transmission Envelopes	31
7.1 General Information	31
7.1.1 Delimiters	31
7.2 Data Detail and Explanation of Incoming ISA to Highmark WV.	34
ISA Interchange Control Header (Incoming).	34
7.3 Data Detail and Explanation of Outgoing ISA from Highmark WV.	35
ISA Interchange Control Header (Outgoing).	35
7.4 Outgoing Interchange Acknowledgment TA1 Segment	37
7.5 Outgoing Functional Acknowledgment 997 Transaction.	37
Chapter 8 • Professional Claim (837P)	39
8.1 General Information and Guidelines for Submitting an 837P	40
8.1.1 Patient with Coverage from an Out-of-State Blue Cross Blue Shield Plan	40
8.1.2 Dental Services	41
8.1.3 Data that is Not Used	41
8.1.4 Transaction Size.	43
8.1.5 Ambulance Claims	43
8.1.6 Provider and Service Facility Location Identification Numbers.	43
8.1.7 Claim Submission Acknowledgment	43

8.1.8 National Provider Identifier (NPI)	44
8.1.9 Balancing	45
8.1.10 Real-Time Claim Adjudication and Estimation	46
8.1.10.1 Real-Time 837 Submission Limitations	46
8.1.10.2 General Requirements and Best Practices	47
8.2 Data Detail for 837P	47
GS <i>Functional Group Header</i>	47
REF <i>Transmission Type Identification</i>	48
NM1 <i>Submitter Name.</i>	49
NM1 <i>Receiver Name</i>	49
PRV <i>Billing/Pay-to Provider Specialty Information.</i>	49
N3 <i>Billing Provider Address</i>	50
N4 <i>Billing Provider City/State/Zip</i>	50
SBR <i>Subscriber Information.</i>	50
NM1 <i>Subscriber Name.</i>	51
NM1 <i>Payer Name.</i>	51
NM1 <i>Patient Name.</i>	52
CLM <i>Claim Information.</i>	52
DTP <i>Date - Date Last Seen</i>	53
DTP <i>Date - Admission</i>	53
PWK <i>Claim Supplemental Information.</i>	53
AMT <i>Total Purchase Service Amount</i>	56
REF <i>Mammography Certification Number.</i>	56
CR2 <i>Spinal Manipulation Information.</i>	56
PRV <i>Referring Provider Specialty Information</i>	57
NM1 <i>Rendering Provider Name</i>	57
PRV <i>Rendering Provider Specialty Information</i>	58
NM1 <i>Service Facility Location</i>	58
N3 <i>Service Facility Location Address</i>	59
N4 <i>Service Facility Location City/State/Zip</i>	59
SBR <i>Other Subscriber Information.</i>	60
AMT <i>COB Patient Paid Amount.</i>	61
NM1 <i>Other Payer Name.</i>	61
SV1 <i>Service Line</i>	62

AMT	<i>Sales Tax Amount</i>	63
PS1	<i>Purchase Service Information</i>	63
LIN	<i>Drug Identification</i>	63
CTP	<i>Drug Pricing</i>	64
NM1	<i>Rendering Provider Name</i>	64
PRV	<i>Rendering Provider Specialty Information</i>	64
REF	<i>Service Facility Location Secondary Identification</i>	65
PRV	<i>Referring Provider Specialty Information</i>	65

Chapter 9 • Institutional Claim (837I)

66

9.1	General Information and Guidelines for Submitting an 837I	68
9.1.1	Patient with Coverage from an Out-of-State Blue Cross Blue Shield Plan	68
9.1.2	Data that is Not Used	69
9.1.3	Transaction Size	70
9.1.4	Number of Lines per Claim	70
9.1.6	Standalone Major Medical	70
9.1.7	Provider Identification Numbers	70
9.1.8	Claim Submission Acknowledgment	71
9.1.9	National Provider Identifier (NPI)	71
9.1.10	Balancing	73
9.1.11	Real Time Claim Adjudication and Estimation	73
9.1.11.1	Real-Time 837 Submission Limitations	74
9.1.11.2	General Requirements and Best Practices	74
9.2	Data Detail for 837I	75
	GS <i>Functional Group Header</i>	75
	REF <i>Transmission Type Identification</i>	77
	NM1 <i>Submitter Name</i>	77
	NM1 <i>Receiver Name</i>	78
	PRV <i>Billing/Pay-To Provider Specialty Information</i>	78
	N3 <i>Billing Provider Address</i>	78
	N4 <i>Billing Provider City/State/Zip</i>	79
	SBR <i>Subscriber Information</i>	79
	NM1 <i>Subscriber Name</i>	80

NM1 Payer Name	80
NM1 Patient Name	81
CLM Claim Information	81
DTP Discharge Hour	82
DTP Admission Date / Hour.	82
PWK Claim Supplemental Information.	83
CN1 Contract Information.	84
REF Original Reference Number (ICN/DCN)	84
K3 File Information	85
HI Principal Procedure Information	86
HI Other Procedure Information.	87
HI Value Information	87
NM1 Attending Physician, Operating Physician, and Other Provider Name.	88
PRV Attending Physician Specialty Information.	89
NM1 Service Facility Name	89
N3 Service Facility Address	89
N4 Service Facility City/State/Zip Code	90
SBR Other Subscriber Information.	90
NM1 Other Payer Name.	91
LIN Drug Identification	91
CTP Drug Pricing	92
NM1 Attending Physician, Operating Physician, and Other Provider Name.	92

Chapter 10 • Claim Acknowledgment (277) 93

10.1 General Information & Guidelines for 277 Claim Acknowledgment	94
10.1.1 Identifying the 837 in the 277 Claim Acknowledgment.	94
10.1.2 Front-End Editing: Level Types 1-5	94
10.1.3 Text Format Options.	95
10.1.4 Timeframe for Batch 277 Claim Acknowledgment	96
10.1.5 Real-Time Claim Acknowledgment	96
10.1.5.1 Claim Adjudication	97
10.1.5.2 Claim Estimation.	97

10.1.5.3 General Requirements and Best Practices 97

Chapter 11 • Claim Payment Advice (835) 99

11.1 General Information and Guidelines for 835.100

11.1.1 Missing Checks100

11.1.2 Administrative Checks100

11.1.3 Availability of Payment Cycle 835 Transactions (Batch) . 100

11.1.4 Highmark WV Private Business and Medicare Supplemental. 100

11.1.5 Highmark WV Major Medical.101

11.1.6 Highmark WV Oral Surgery.101

11.1.7 Unavailable Claim Data101

11.1.8 Claim Overpayment Refunds102

11.1.8.1 Institutional Claims 102

11.1.8.2 Professional Claims 103

11.1.9 Electronic Funds Transfer (EFT)104

11.1.10 Capitation Payments104

11.1.11 Member Identification Numbers104

11.1.12 Data that is Not Used104

11.1.13 National Provider Identifier (NPI)105

11.1.14 Provider Payments from Member Health Care Accounts106

11.1.15 Real-Time 835 Response.108

11.1.15.1 Real-Time Response for Claim Adjudication 108

11.1.15.2 Real-Time 835 Response for Claim Estimation 109

11.1.15.3 General Requirements and Best Practices 111

11.2 Data Detail for 835.112

GS Functional Group Header	113
BPR Financial Information	114
REF Receiver Identification	115
REF Additional Payer Identification	115
LX Header Number.	116
N1 Payee Identification	116
REF Payee Additional Identification.	117
CLP Claim Payment Information	117
NM1 Service Provider Name	118
REF Other Claim Related Identification	118
SVC Service Payment Information.	119
PLB Provider Adjustment.	119

Chapter 12 • Claim Status (276 & 277) 121

12.1 General Instructions and Guidelines for 276 and 277.	121
12.1.1 General Instructions and Guidelines for 276	122
12.1.1.1 General Description	122
12.1.1.2 Dental Services	122
12.1.1.3 Data that Is Not Used	122
12.1.1.4 Minimum Requirements	123
12.1.1.5 Situational Elements and Data Content	124
12.1.1.6 Requests Per Transaction Mode	124
12.1.1.7 Patient with Coverage from an Out-of-State Blue Cross Blue Shield Plan	125
12.1.2 General Instructions and Guidelines for 277	125
12.1.2.1 General Description of 277.	125
12.1.2.2 Claim Splits.	125
12.1.2.3 Customer Service Requests.	126
12.1.2.4 Maximum Claim Responses per Subscriber/Patient/Depen- dent.	126
12.1.2.5 Corrected Subscriber and Dependent Level	126
12.1.2.6 National Provider Identifier.	126
12.2 Data Detail for 276	126
GS Functional Group Header	127

NM1 Payer Name.	128
NM1 Information Receiver Name.	129

NM1 Provider Name.	129
NM1 Subscriber Name.	130
REF Payer Claim ID Number	130
12.3 Data Detail for Claim Status Response (277).	131
GS Functional Group Header	131
NM1 Provider Name	132
REF Payer Claim Identification Number.	132

Chapter 13 • Eligibility Request-270 / Response-271 133

13.1 General Instructions and Guidelines for 270 and 271.	134
13.1.1 Mt State Requirements.	134
13.1.2 Dental and Oral Surgery Inquiries	134
13.1.3 Definition of Active Coverage	134
13.1.4 Benefit Inquiries	134
13.1.5 Allowable Time Frames for Inquiries	135
13.1.6 Disclaimers.	135
13.1.7 Dates on the Incoming 270.	135
13.1.8 Range Dates on the Incoming 270.	135
13.1.9 Level of Detail on Outbound 271	136
13.1.10 Specific Service Code Request	136
13.1.11 Generic Service Code Request	136
13.1.12 Real-Time Request.	136
13.1.13 (Left blank intentionally).	137
13.1.14 Data that is Not Used	137
13.1.15 Requests Per Transaction Mode	137
13.1.16 Date Ranges Submitted on the 270	138
13.1.17 Minimum Amount of Data Required for Search	138
13.1.18 Patient with Coverage from an Out-of-State Blue Cross Blue Shield Plan.	138
13.2 270/271 Data Detail Instructions.	139
13.2.1 Data Detail for Eligibility Request (270)	139
GS Functional Group Header	139
BHT Beginning of Hierarchical Transaction	140

NM1 Information Source Name	140
NM1 Information Receiver Name.	141
<hr/>	
NM1 Subscriber/Dependent Name.	141
REF Subscriber/Dependent Additional Identification	142
PRV Provider Information.	142
EQ Subscriber/Dependent Eligibility or Benefit Inquiry In formation	143
III Subscriber/Dependent Eligibility or Benefit Inquiry Information.	143
13.2.2 Data Detail for Eligibility Response (271).	144
GS Functional Group Header	144
NM1 Information Receiver Name	145
NM1 Subscriber/Dependent Name.	145
N3 Subscriber/Dependent Address.	146
N4 Subscriber/Dependent City, Street, Zip Code	146
DTP Subscriber/Dependent Date.	146
REF Subscriber/Dependent Additional Information	147
DTP Subscriber/Dependent Eligibility/Benefit Date	147
MSG Message Text	147

Chapter 14 • Health Care Services Review (278)—Request and Response 148

14.1 General Information and Guidelines for Submitting a 278	148
14.1.1 Real-Time Requests.	148
14.1.2 Data that is Not Used	149
14.1.3 Patient with Coverage from an Out-of-State Blue Cross Blue Shield Plan	149
14.2 Data Detail Instructions.	149
14.2.1 Data Detail for Services Review Request (278)	150
GS Functional Group Header	150
N M1 Utilization Management Organization (UMO) Name	151
N3 Requester Address	151
N4 Requester City/State/Zip Code	152
PER Requester Contact Information	152
HI Subscriber/Dependent Diagnosis	153
PWK Additional Patient Information.	153

N M1 <i>Subscriber/Dependent Name</i>	154
DMG <i>Subscriber/Dependent Demographic Information</i>	155

HL <i>Service Provider Level</i>	155
N3 <i>Service Provider Address</i>	156
N4 <i>Service Provider City/State/Zip Code</i>	156
PER <i>Service Provider Contact Information</i>	156
UM <i>Health Care Services Review Information</i>	157
HI <i>Procedures</i>	158
14.2.2 Data Detail for Services Review Response (278)	159
GS <i>Functional Group Header</i>	159

Appendix A • Highmark Health Insurance Company 160

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 West Virginia. This guide also applies to the above referenced transactions that are being transmitted to Highmark West Virginia by a clearinghouse.

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

Highmark West Virginia'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 West Virginia EDI Operations supports transactions for multiple payers; each transaction chapter lists the supported payers for that transaction.

While Highmark West Virginia 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 West Virginia 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 West Virginia'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 West Virginia 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: <ul style="list-style-type: none"> • Services Review — Request for Review (Referral/Authorization Request) • Services Review — Response to Request for Review
837 Transaction	Three implementations of this transaction: <ul style="list-style-type: none"> • Institutional • Professional • Dental <p>NOTE: Dental transactions (837Ds) for Highmark West Virginia products must be sent to Highmark West Virginia'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.</p>

835 Transaction	Claim Payment/Advice (Electronic Remittance)
834 Transaction	Benefit Enrollment and Maintenance
820 Transaction	Premium Payment

Employer/Sponsor Transactions

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

Acknowledgment Transactions

1.2 Real-Time Transaction Capability

Highmark West Virginia supports all of the EDI transactions listed in Section 1.1 in batch mode. Additionally, Highmark West Virginia 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 West Virginia maintains separate specifications detailing the technical internet connectivity requirements for Highmark West Virginia's real-time processes. These connectivity specifications can be found at the following link:

<https://www.highmark.com/edi-wv/pdfs/rtguide.pdf>

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 West Virginia 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 West Virginia's EDI Reference guidelines for development of the EDI transactions used in the real-time processes.

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 X1 2 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-wv/pdfs/4010providerguide.pdf>

Contact Information

Contact information for Highmark West Virginia EDI Operations:

Address: EDI Operations

P.O. Box 1948

Parkersburg, WV 26102-1948

TELEPHONE NUMBER: (304) 424-7728 or
(888) 222-5950

FAX NUMBER: (304) 424-9810

EMAIL ADDRESS: hmwvedi@highmark.com

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

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

Claims Customer Service – Parkersburg (888) 809-9121

Claims Customer Service - Wheeling	(800) 543-7822
FEP Customer Service – Parkersburg	(800) 535-5266
FreedomBlue Provider Services	(888) 798-7768
Dental (Commercial Products)	(800) 332-0366
Dental (TriCare Dental Programs)	(800) 866-8499
Member Services	(888) 459-4020
TTY	(800) 855-1155

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

2.1 System Operating Hours

Highmark West Virginia 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 West Virginia EDI Trading Partners transmit any test data during the hours that Highmark West Virginia EDI Operations support is available.

2.2 Provider Data Services

To obtain the status of a provider’s application for participation with any Highmark West Virginia provider network, please contact Provider File Maintenance (800) 798-7768 or (304) 424-7795. Also, use this number to update provider data currently on file with Highmark West Virginia. Note that this number only serves Highmark West Virginia 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 West Virginia 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 West Virginia 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 West Virginia can accept characters from the basic and extended character sets with the following exceptions:

<u>Character</u>	<u>Name</u>	<u>Hex value</u>
!	Exclamation point	(21)
>	Greater than	(3E)
^	Caret	(5E)
	Pipe	(7C)
~	Tilde	(7E)

These five characters are used by Highmark West Virginia 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 West Virginia 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 West Virginia 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 West Virginia and its Trading Partners will comply with the privacy standards for all EDI transactions as outlined in the Highmark West Virginia 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 West Virginia 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 West Virginia for the submission of EDI transactions. This form must be completed by an authorized representative of the organization.

Highmark West Virginia 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 EDI Transaction Application and agree to the terms of Highmark West Virginia'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 Application from the page accessed by the link below:

<https://www.highmark.com/edi-wv/pages/forms.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, Please click on the following link:

<https://secure.highmark.com/eoptpp/EnrollForms?organizationcode=MTST>

4.3 Adding/Deleting Providers to an Existing Trading Partner

Trading Partners currently using electronic claim submission who wish to add or delete providers to their Trading Partner Number should click on the link below:

<https://secure.highmark.com/eoptpp/EnrollForms?organizationcode=MTST>

4.4 Reporting Changes in Status

Trading Partners changing their information must inform EDI Operations by clicking on the link below:

<https://www.highmark.com/edi-wv/pages/forms.shtml>

4.5 Out of State Providers

Due to an operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association, Highmark West Virginia cannot accept electronic transactions from out of state nonparticipating/out-of network providers for Highmark West Virginia 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.

For Highmark Health Insurance Company, see Appendix A.

5 Testing Policy

Highmark West Virginia 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 West Virginia-customized version of Foresight Corporation's HIPAA Community Manager® product. Web-based testing is available for claims where the Interchange Receiver ID (ISA08) is Highmark West Virginia (54828) or Highmark Health Insurance Company (HHIC) Medicare Advantage (71768). 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 West Virginia or HHIC. 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 West Virginia 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 Community Manager®, please visit their Web site describing the product at <http://foresightcorp.com>.

If you need assistance during your Community Manager® testing, you may call EDI Operations at 888-222-5950 or e-mail us at hmwvedi@highmark.com. A member of our support staff will be available Monday through Friday 8:00 a.m. to 4:00 p.m. ET to assist with any HIPAA Community Manager® Trading Partner Testing questions you may have.

To get started, you need a Highmark West Virginia 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 West Virginia Transactional Testing

The second level involves connecting to Highmark West Virginia and submitting a transaction file. Transactions will be taken into Highmark West Virginia'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 West Virginia 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 West Virginia Real-Time 837 Estimation Demonstration Process for information on the testing process for a real-time 837 transaction.

NOTE: Highmark West Virginia 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 West Virginia's implementation of this transaction.

Trading Partners may choose to submit test transactions to Highmark West Virginia 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 West Virginia'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 West Virginia, as well as submit an 837 Estimation which will be edited for X12 syntax and Highmark West Virginia 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 West Virginia business editing. The 277CA transaction will return actual editing results.
- If the 837 Estimation transaction passes the X12 syntax and Highmark West Virginia 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 at the following link:

<https://www.highmark.com/edi-wv/pdfs/rtguide.pdf>

6 Communications

Highmark West Virginia 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 West Virginia. In order to submit electronically via modem, you will need a computer, modem, and software programmed with the option to submit electronically to Highmark West Virginia. 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 West Virginia, 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 West Virginia offers two methods to utilize the Internet for conducting electronic business with Highmark West Virginia. 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia. 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 West Virginia 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 West Virginia. Once completed, the file will appear in your file list.

8. Retrieve a file from Highmark West Virginia. The following is an example of retrieval of a 997 Functional Acknowledgment file:
 - a. Click on the “hipaa-out” directory.our browser will list all the files available to you.
 - b. Click on the “997” directory.
 - c. 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 West Virginia 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 West Virginia, a Trading Partner will need to:

Check with your EDI software vendor to ensure that the EDI transaction software is programmed for Highmark West Virginia’s real-time/ SOAP

transactions. For instructions on how to program for Highmark West Virginia's real-time transactions, refer to the "Real-Time Inquiry Connectivity Specifications" or "Real-Time Claim Adjudication and Estimation Connectivity Specifications" located on the Highmark West Virginia website. Go to the "Resource" section and choose "EDI Reference Guides".

- Complete an EDI Transaction Application
 - o Select the real-time transaction option.
 - o Include your email address.
 - o 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 West Virginia’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 West Virginia 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 West Virginia 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	1 E
!	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 West Virginia 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 West Virginia

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 WV can only support code 00 - No Authorization Information present.
ISA02	Authorization Information	This element must be space filled.
ISA03	Security Information Qualifier	Highmark WV 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 WV 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 WV only supports the NAIC code to identify the receiver (Highmark WV).

Data Element Summary

Ref Des.	Element Name	Element Note
ISA08	Interchange Receiver ID	Highmark WV, designated by NAIC code of 54828, must be identified as the Interchange Receiver <ul style="list-style-type: none"> Highmark Health Insurance Company (HHIC) FreedomBlue and Medicare Advantage transactions, see Appendix A.
ISA14	Acknowledgment Requested	Highmark WV does not consider the contents of ISA14. A TA1 segment is returned when the incoming interchange is rejected.
ISA15	Usage Indicator	Highmark WV 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 West Virginia

Segment: **ISA** Interchange Control Header (Outgoing)

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

Data Element Summary

Ref Des.	Element Name	Element Note
ISA01	Authorization Information Qualifier	Highmark WV can only support code 00 - No Authorization Information present.

Data Element Summary

Ref Des.	Element Name	Element Note
ISA02	Authorization Information	This element must be space filled.
ISA03	Security Information Qualifier	Highmark WV can only support code 00 - No security Information present.
ISA04	Security Information	This element must be space filled.
ISA05	Interchange ID Qualifier	Highmark WV will send qualifier code value “33” to designate that the NAIC code is used to identify the sender.
ISA06	Interchange Sender ID	<p>Highmark WV EDI Operations, designated by Highmark WV's NAIC code of 54828, will be identified as the Interchange Sender.</p> <p>Highmark Health Insurance Company (HHIC) NAIC code 71768 FreedomBlue and Medicare Advantage transactions, see Appendix A.</p>
ISA07	Interchange ID Qualifier	Highmark WV will send qualifier code value “ZZ” Mutually Defined, to designate that a Highmark West Virginia -assigned proprietary ID is used to identify the receiver.
ISA08	Interchange Receiver ID	The Highmark WV-assigned ID will be the trading partner's security logon ID. This ID will be left-justified and space filled.
ISA 14	Acknowledgment Requested	Highmark West Virginia always uses a 0 (No Interchange Acknowledgment Requested).
ISA 15	Usage Indicator	Highmark WV 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 West Virginia 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 West Virginia TA1 will have an Interchange control envelope (ISA - IEA).

7.5 Outgoing Functional Acknowledgment 997 Transaction

Highmark West Virginia 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 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^      ^33^54828      ^ZZ^XXXXXXXX
^060926^ 1 429^U^0040 1 ^03 573 8627^0^P^>
GS^FA^XXXXX^999999^20060926^1 42948^ 1 ^X^0040 10
ST^997^000 1
AK1^HC^655
AK2^837^PA03
AK3^GS^1 14^^8
AK4^2^^7^TRADING PARTNER PROFILE
AK5^R
AK9^R^1^1^0
SE^ 8^000 1
GE^1 ^1
IEA^1^035738627
```

Highmark West Virginia 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 related to the following Highmark West Virginia Traditional and Managed Care Products: Preferred Provider Organization (PPO), Point of Service (POS), Traditional Indemnity, Comprehensive Major Medical, Medicare Supplemental, FEP, and Medicare Advantage.

Accurate reporting of NAIC codes to identify the appropriate payer and to control routing is critical for claims submitted to Highmark West Virginia 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 54828 for these benefit programs)
- Application Receiver, GS03 (54828)
- Receiver ID (1000B NM109) in the 837 transaction (always 54828 for these benefit programs)
- Payer ID (2010BB NM 109) in the 837 transaction (54828)



Additional Payers

Highmark Health Insurance Company (HHIC) Medicare Advantage FreedomBlue, see Appendix A.

837P Payer ID Chart

Send to Highmark West Virginia EDI

(ISA08 Interchange Receiver ID and 837 Transaction Loop 1000B NM109 Receiver ID = 54848)

Product	Member ID Alpha Prefix	PAYER Loop 2010BB NM1 09 Payer ID (GS03 Application Receiver MUST match Payer ID)
Highmark West Virginia Indemnity, CMM, HMO, PPO, POS, Medicare Supplemental, Federal Employees Health Benefit Plan.	Various prefixes; "R" for FEHBP; or none.	54828
Blue Card	various	54828
HHIC Medicare Advantage FreedomBlue (plan code 377) Products	HQM, HKP	71768
Medicare Advantage PPO Reciprocal Network Sharing  Identified by  logo on ID card Alpha prefix	various	71768

8.1 General Information and Guidelines for Submitting an 837P

8.1.1 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 West Virginia to accept 837P claims when the patient has coverage from an out-of-state Plan. To

February 1, 2011

be processed through this arrangement, the Member ID (Subscriber, and Patient ID if sent) must be submitted with its alpha prefix. Also, Highmark West Virginia must be listed as the payer. (54828 in the Application Receiver GS03 and in the Payer ID loop 2010BB NM109) Highmark West Virginia 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 West Virginia member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark West Virginia'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 West Virginia 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 West Virginia.

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 West Virginia'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 West Virginia 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 West Virginia'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 West Virginia'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, CLM1 6 (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 West Virginia 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 West Virginia 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 Ambulance Claims

Ambulance claims submitted for a Security Blue 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.

8.1.6 Provider and Service Facility Location Identification Numbers

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

8.1.7 Claim Submission Acknowledgment

Highmark West Virginia 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 West Virginia'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 54828. 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.

8.1.8 National Provider Identifier (NPI)

Highmark West Virginia can accept the National Provider Identifier (NPI) on electronic claims. General information regarding Highmark West Virginia's NPI project can be found by selecting the 'HIPAA – National Provider Identifier' link from the Provider Resource Center on Highmark West Virginia'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 West Virginia 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 West Virginia IDs will encounter significant transactional changes dependent upon the data required to identify the specific Highmark West Virginia provider entity that is requesting payment. In these instances, Highmark West Virginia 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 West Virginia provider IDs and elects to enumerate with only one NPI. The difference between the multiple Highmark West Virginia IDs is different practicing specialties. The location of services rendered is the same across the multiple IDs.

Current:

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

Current:

- Submit Highmark West Virginia 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.
- 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 231 0D) when the location was alternate to the primary location.

8.1.9 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.

8.1.10 Real-Time Claim Adjudication and Estimation

Effective November 7, 2008, Highmark West Virginia 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 .10.1 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 .10.2 General Requirements and Best Practices

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

- Best Practice: Highmark West Virginia 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 West Virginia.

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 West Virginia assigned Trading Partner Number. The submitted value must not include leading zeroes. To support Highmark West Virginia's routing process for real-time claim adjudication or estimation, the sender's Highmark West Virginia-assigned Trading Partner number

GS03	Application Receiver's Code	Highmark West Virginia 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. Following is a list of recognized payers and their ID codes:
------	-----------------------------	---

54828 – Highmark West Virginia

71768 - Highmark Health Insurance Company (HHIC)
Medicare Advantage FreedomBlue

GS06	Group Control Number	Highmark WV 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 0040 10X098A1 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 WV 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 54828 to identify Highmark West Virginia. Use 71768 to identify HHIC as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. 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 West Virginia -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 West Virginia.

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 West Virginia 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
NM 109	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
NM 109	Payer Identifier	Submit the NAIC number for the destination payer. Following is a list of recognized payers and their respective NAIC codes: 54828 – Highmark West Virginia 71768 – HHIC Medicare Advantage FreedomBlue

February 1, 2011

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 West Virginia'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.

February 1, 2011

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 accessed by clicking the following link:

<https://www.highmark.com/edi-wv/pdfs/pwksheet.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 WV 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 West Virginia 's business practices and policy only support the following transmission types at this time:

- AA - Available on Request
- BM - By Mail; mail to Highmark WV Attachments, PO Box 7026, Wheeling WV 26003-0766.
- FX - By Fax; fax to (304) 234-7086.

February 1, 2011

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: 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 West Virginia'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 West Virginia requires that the individual provider who performed the service be identified in this 231 0B 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 West Virginia assigned provider numbers.

The provider identified in this 231 0B 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 23 10B Rendering Provider NM109, Highmark West Virginia’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 West Virginia 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 West Virginia 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. -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 West Virginia 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: CP Medicare Conditionally Primary MB Medicare Part B 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: 16 Health Maintenance Organization (HMO) Medicare Risk 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.

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.

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	<p>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.</p> <p>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.</p>
SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	<p>For anesthesia services where the billing provider is not a Certified Registered Nurse Anesthetist (CRNA), Highmark West Virginia requires submission of one of the following anesthesia certification modifiers: AA - AE, GC, QK, QX, QY, or WP. If the billing provider is not participating or is not in West Virginia, code values QZ and 47 are also valid.</p> <p>For anesthesia services where the billing provider is a CRNA, Highmark West Virginia requires submission of one of the following anesthesia certification modifiers: QX, QZ, or 47. If the billing provider is not participating or not in West Virginia, code values AA - AE, GC, QK, QY, and WP are also valid.</p>
SV103	Unit Measurement Code	<p>For anesthesia services, the payer's business policy requires that minutes are reported. Therefore, for anesthesia services, including conscious sedation codes 99141 and 99142, the code value in SV103 must be MJ, Minutes, and the actual number of minutes are reported in SV104. Note that anesthesia modifying unit procedure codes are reported with UN, Units, and not minutes.</p>

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 West Virginia.

Note 3: Highmark West Virginia 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 West Virginia 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 231 0B loop for this service line. The 2420A loop can not be used without a 231 0B 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 West Virginia'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 West Virginia'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.

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

- Highmark West Virginia - 54828
(includes Highmark West Virginia Indemnity, Preferred Provider Organization PPO, Point of Service POS, Comprehensive Major Medical CMM, Major Medical, FEP 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

- Highmark Health Insurance Company (HHIC), see Appendix A

**837P Payer ID Chart****Send to Highmark West Virginia EDI**

(ISA08 Interchange Receiver ID and 837 Transaction Loop 1000B NM109 Receiver ID = 54828)

Product	Member ID Alpha Prefix	PAYER Loop 2010 BC NM109 Payer (GS03 Receiver MUST match Payer ID)	Companion Document
Highmark West Virginia Indemnity, CMM, MM, PPO, POS, Medicare Supplemental, Federal Employees Health Benefit Plan.	Various prefixes; "R" for FEHBP; or none.	54828	Highmark West Virginia

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 West Virginia to accept 837I claims from those facility providers that send their Highmark West Virginia 837I claims to Highmark West Virginia 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 West Virginia must be listed as the payer by submitting Highmark West Virginia's NAIC code of 54828 with the appropriate W or C suffix (see GS03 note) in the GS03 Application Receiver's Code and the loop 2010BC NM 109 Payer ID. Highmark West Virginia 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 West Virginia member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark West Virginia'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 West Virginia to be an electronic interface for its local providers to out-of-state Plans that are licensees of the Blue Cross Blue Shield Association.

9.1.2 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 West Virginia'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 West Virginia'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 West Virginia 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 West Virginia 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 West Virginia 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.

9.1.6 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 West Virginia provider number, it is important that no leading zeros or alpha characters be submitted along with the Highmark West Virginia assigned identification

number.

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 West Virginia 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 West Virginia'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 54828. 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 West Virginia can accept the National Provider Identifier (NPI) on electronic claims. Transaction specifications for submitting claims with the NPI are outlined in the data detail section that follows.

Providers that enumerate their current Highmark West Virginia 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 West Virginia IDs will encounter significant transactional changes dependent upon the data required to identify the specific Highmark West Virginia provider entity that is requesting payment. In these instances, Highmark West Virginia 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 West Virginia provider IDs and elects to enumerate with only one NPI. The difference between the multiple Highmark West Virginia IDs is different practicing specialties. The location of services rendered is the same across the multiple IDs.

Current:

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

Current:

- Submit Highmark West Virginia 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 231 0E) 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 West Virginia 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 West Virginia 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 West Virginia.

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 West Virginia assigned Trading Partner Number. The submitted value must not include leading zeroes. To support Highmark West Virginia's routing process for real-time claim adjudication or estimation, the sender's Highmark West Virginia -assigned Trading Partner number

Note: For more information on distinguishing the type of real-time 837 claim request, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications'. To access the guide, please

click on the link below:

<https://www.highmark.com/edi-wv/pdfs/rtguide.pdf>

Data Element Summary

Ref Des.	Element Name	Element Note
GS03	Application Receiver's Code	Highmark West Virginia 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 West Virginia's NAIC number. The value in this element should correspond to the NAIC number submitted as the payer ID in the Payer Name segment in loop 2010BC.
GS06	Group Control Number	Highmark West Virginia does not have specific requirements 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 0040 10X096A1 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	Highmark WV 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 54828 – This value identifies Highmark WV as the receiver of the transaction and corresponds to the value in the 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 West Virginia'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

RefDes.	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 West Virginia 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
NM 109	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
NM 109	Identification Code	Submit Highmark WV's NAIC number 54828.

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 WV'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	<p>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.</p> <p>Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.</p>

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	<p>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.</p> <p>Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.</p>

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 West Virginia'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 Claim Information Cover sheet must be used when faxing or mailing supplemental information in support of an electronic claim. 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 accessed by clicking on the following link:

<https://www.highmark.com/edi-wv/pdfs/pwksheet.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 WV 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	Report Transmission Code	Highmark West Virginia’s business practices and policy only support the following transmission types at this time: <ul style="list-style-type: none"> • AA - Available on Request at Provider Site. • BM - By Mail; mail to Highmark West Virginia Attachments, PO Box 7026, Wheeling, WV 26003-0766 • FX - By Fax; fax to 304-234-7086

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 West Virginia 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 West Virginia’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 was communicated through a Highmark West Virginia facility bulletin.

Data Element Summary

Ref. Des.	Element Name	Element Note
K301	Fixed Format Information	<p>The fixed format for reporting POA's is as follows:</p> <ul style="list-style-type: none"> • Positions 1 - 3 = POA • Position 4 = POA Indicator for the Principal Diagnosis (HI segment with BK qualifier) • Positions 5 - ? = POA indicators for all Other Diagnosis Codes (HI segment with BF qualifier) that are reported. • 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. • Next position = POA Indicator for External Cause of Injury Code (E-Code), if an E-Code is reported on this claim. <p><u>POA Indicator Values</u> Y = Yes N = No U = Unknown W = Clinically undetermined 1 = Diagnosis code is exempt from reporting of POA</p> <p><u>End of List Code Values</u> Z = Indicates the end of diagnosis code POA indicators. X = Indicates the end of diagnosis code POA indicators when there are special processing situations (exception handling).</p> <p><u>Examples</u> K3*POAYNUZY~ No exception handling; e-code reported. K3*POANZ~ No exception handling; no e-code reported. K3*POAY1XY~ Exception handling; e-code reported.</p>

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	<p>As required by the federal Electronic Transaction rule, ICD-9-CM procedure codes (qualifier BR) must be used to report hospital inpatient services.</p> <p>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.</p>

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	<p>As required by the federal Electronic Transaction rule, only ICD-9-CM procedure codes (qualifier BQ) must be used to report hospital inpatient services.</p> <p>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.</p>

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 West Virginia 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 231 0E 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**

RefDes.	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 West Virginia 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: 16 Health Maintenance Organization (HMO) Medicare Risk MA Medicare Part A MB Medicare Part B

Segment: **NM1** Other Payer Name

Loop: 2330B

4010 IG Page: 411

Data Element Summary

Ref Des.	Element Name	Element Note
NM 109	Identification Code	<p>Until the National Health Plan ID is established, this NM 109 data element will only be used to match to the corresponding information in the 2430 loop.</p> <p>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.</p> <p>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.</p>

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	<p>4010 Non-Addenda - The CTP segment is not available in the non-addenda standard.</p> <p>4010A1 Addenda - Maximum length is 10 characters including reported or implied cents.</p>

**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 NM1 09, Highmark West Virginia'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 West Virginia. The Payer Code is listed for reference:

- Highmark West Virginia - 54828
Includes Indemnity, Comprehensive Major Medical (CMM), Major Medical (MM), Preferred Provider Organization (PPO), Point of Service (POS), Medicare Supplemental, Federal Employees Health Benefit Plan.

Additional Payers

Highmark Health Insurance Company (HHIC), see Appendix A.

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 West Virginia 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 West Virginia. The Payer Code is listed for reference:

- Highmark West Virginia - 54828
Includes Indemnity, Comprehensive Major Medical (CMM), Major Medical (MM), Preferred Provider Organization (PPO), Point of Service (POS), Medicare Supplemental, Federal Employees Health Benefit Plan.

10.1.2 Front-End Editing: Level Types 1-5

DELAYED: Effective November 7, 2008. Highmark West Virginia 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 (X1 2) 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia claims (Payer Code 54828). 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 888-222-5950. 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 West Virginia 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 Real-Time Claim Acknowledgment

Effective November 7, 2008, Highmark West Virginia 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 West Virginia'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 .5.1 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 .5.2 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.

10.1.5.3 General Requirements and Best Practices

Trading Partners must process the acknowledgement response returned from Highmark West Virginia.

- 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 West Virginia's EDI Operations for patients with Highmark West Virginia, Federal Employees Health Benefit Plan, BlueCard Par Point of Service (POS) coverage. Highmark West Virginia (NAIC code 54828) will be designated as the payer for all of these payments.

Additional Payers

- Highmark Health Insurance Company (HHIC), see Appendix A.

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 West Virginia'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.

11.1.4 Highmark West Virginia Private Business and Medicare Supplemental

Highmark West Virginia 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 West Virginia's NAIC code 54828. 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 West Virginia Major Medical

Under certain group contracts, Highmark West Virginia 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 West Virginia Oral Surgery

Claims for oral surgery services that are processed through Highmark West Virginia Medical-Surgical health care products will be reported in Highmark West Virginia'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 West Virginia. 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia, 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 West Virginia, 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 West Virginia'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 West Virginia that contain the details of an overpayment.

In the 835 transaction, the Highmark West Virginia -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: '061 23456789DEFER.'
- 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 West Virginia 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 West Virginia 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)

Highmark West Virginia 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 form can be by clicking the link below:

<https://www.highmark.com/edi-wv/index.shtml>

Please be advised that for each NPI or billing provider number, Highmark West Virginia 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia 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 West Virginia will continue to create an 835 transaction to document Highmark West Virginia'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 West Virginia 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 West Virginia 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 West Virginia. 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 West Virginia 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 West Virginia and Payment from the Member’s Account

The example below illustrates the ‘COB reporting model’ and 835 segments documenting claim payment from Highmark West Virginia under the patient’s health care coverage plan and reimbursement from the patient’s health care account. For purposes of ERA reporting only, Highmark West Virginia’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 West Virginia allowance for the procedure is \$180, leaving a contractual obligation of \$20. Highmark West Virginia 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 West Virginia) 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 West Virginia Payment (Primary)	Highmark West Virginia Health Care Account Payment (Secondary)
N1^PR^HIGHMARK WEST VIRGINIA~	N1^PR^HIGHMARK WEST VIRGINIA HEALTH
CLP^ABC123^1^200^50^1 30^12^0123456789~	CARE ACCOUNT~ CLP^ABC123^2^200^1
NM1^QC^1^DOE^JOHN^^^^MI^3334455551 0~	30^12^0123456789~
SVC^HC>99245^200^50~	NM1^QC^1^DOE^JOHN^^^^MI^33344555510~
DTM^1 50^20060301~	SVC^HC>99245^200^130~
DTM^1 5 1^20060304~	DTM^1 50^20060301~
CAS^CO^45^20~	DTM^1 5 1^20060304~
CAS^PR^1^130~	CAS^OA^23^70~

11.1.15 Real-Time 835 Response

Effective November 7, 2008, Highmark West Virginia 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	<p>CAS Segment will report all member and provider contractual liabilities.</p> <p>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.</p> <p>CAS*OA*101*\$\$\$\$</p> <p>CAS is reported at the applicable Line or Claim level.</p>

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 West Virginia recommends the 'Member Liability Statement' format and data presented be modeled after the statements developed by Highmark West Virginia.

- Best Practice: Trading Partners are recommended to have the dynamic statement printed on the Member Liability Statement that reads "Administered by Highmark West Virginia Blue Cross 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 WV will send the NAIC code for the Payer that is sending this transaction: <u>VALUE PAYER</u> 54828 Highmark West Virginia
GS03	Application Receiver's Code	This will be the electronic Trading Partner Number assigned by Highmark West Virginia's EDI Operations for transmission of 835 Transactions.
GS06	Group Control Number	Highmark WV 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. 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. CHK will be utilized when payment is made via check. NON will be utilized when the payment amount for the batch (payment cycle) 835 is zero. 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 West Virginia '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 West Virginia will send the NAIC code for the Payer that is sending this transaction: <u>VALUE PAYER</u> 54828 Highmark West Virginia 71768 HHIC

LX Header Number

Loop: 2000

4010 IG Page: 79

Data Element Summary

Ref Des.	Element Name	Element Note
LX01	Assigned Number	<p>A number assigned for the purpose of identifying a sorted group of claims. Values:</p> <ol style="list-style-type: none"> 1. All claims except Highmark West Virginia Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period. 2. (To be implemented Jan 19, 2007) Highmark West Virginia Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period.

Segment: N1 Payee Identification

Loop: 1000B

4010 IG Page: 72, 73

Data Element Summary

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

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.

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 Codes	Highmark West Virginia uses the 'finalized' Claim Status identified in the national implementation guide for adjudicated claims. NOTE: Highmark West Virginia will use the following value for status on a real-time estimation response. 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. UP - will be utilized for Institutional claims. 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. 1W - will be passed on Highmark West Virginia's Medicare Supplemental 835 to provide the patient's Member ID when the patient is also the Insurance CE (Professional claims) - This value will be utilized to provide the payer's Class of Contract Code in REF02. CE (Highmark West Virginia 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

RefDes	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: 99199 - Unlisted HCPCS Procedure code. (SVC01-1 qualifier is HC) 0949 - Unlisted Revenue code. (SVC01-1 qualifier is NU)

Segment: **PLB** Provider Adjustment

Loop:

4010 IG Page: 165-172

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.

Data Element Summary

Ref Des.	Element Name	Element Note
PLB03-1	Provider	<p>Values noted will be passed when applicable for reducing or increasing the provider's check.</p> <p>CS - Adjustment</p> <p>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.</p> <p>FB - Forwarding Balance</p> <p>This value will be used to reflect balance forward refund amounts between weekly 835 transactions. See Section 11.1.8 for more information.</p> <p>L6 - Interest Owed</p> <p>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.</p> <p>WO - Overpayment Recovery</p> <p>This value will be used for recouping claim overpayments and reporting offset dollar amounts. See Section 11.1.8 for more information.</p>
PLB05-1	Adjustment Reason	
PLB07-1	Code	
PLB09-1		
PLB 11-1		
PLB 13-1		
PLB03 -2	Provider	<p>Institutional - When the Adjustment Reason Code is "FB" or "WO", the Provider Adjustment Identifier will contain the Highmark West Virginia Claim Number for the claim associated to this refund recovery.</p> <p>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 West Virginia Claim Number for the claim associated to this refund recovery. For Highmark West Virginia 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</p>
PLB05-2	Adjustment	
PLB07-2	Identifier	
PLB09-2		
PLB 11-2		
PLB 13-2		

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 West Virginia

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

- Highmark West Virginia - 54828

Includes Indemnity, Comprehensive Major Medical (CMM), Major Medical (MM), Preferred Provider Organization (PPO), Point of Service (POS), Medicare Supplemental and Federal Employees Health Benefit Plan.

Additional Payers

Highmark Health Insurance Company (HHIC), see Appendix A

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 West Virginia'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 West Virginia 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 pending claim is found.

121.1.4 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	(21 00D)
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 West Virginia 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 West Virginia 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 West Virginia must be listed as the payer by submitting Highmark West Virginia's NAIC code of 54828 in the GS03 Application Receiver's Code and the loop 2100A NM109 Payer ID. Highmark West Virginia 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 West Virginia 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

February 1, 2011

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 Identification 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 West Virginia 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 West Virginia.

12.1.2.6 National Provider Identifier

Providers that enumerate their current Highmark West Virginia 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 West Virginia 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 Partner	Application	Use the sender's Highmark West Virginia -assigned Trading
	Sender's Code	Number, with a prefix of B or R as follows: B = requesting batch mode response. R = requesting real-time response. The submitted value must not include leading zero's.
GS03	Application Receiver's Code	To support Highmark West Virginia'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: 54828 - Highmark West Virginia
GS06 N	Group Control Number	Highmark WV 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
NM 108	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 NM 109.
NM 109	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. 54828 - Highmark West Virginia 71768 – HHIC Medicare Advantage FreedomBlue

Segment: **NM1** Information Receiver Name

Loop: 2100B

4010 IG Page: 63

Data Element Summary

Ref Des.	Element Name	Element Note
NM 108	Identification Code Qualifier	The payers' Claim Status process requires the use of the Trading Partner Number as assigned by Highmark West Virginia EDI Operations. This must be designated by a code value in this data element of "46", Electronic Transmitter Identification Number.
NM 109	Information Receiver Identification Number	Send Trading Partner Number as assigned by Highmark West Virginia'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
NM 108	Identification Code Qualifier	Send the provider's National Provider Identifier (NPI). Place qualifier xx in NM108 and the actual identifier in NM 109.

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

Ref Des.	Element Name	Element Note
NM 108	Identification Code Qualifier	Use code value "MI", Member Identification Number.
NM 109	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. Note 1 - this is not the Patient Account Number. 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 WV will send the NAIC code for the Payer that is sending this response: <table style="margin-left: 20px; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 100px;">VALUE</td> <td style="border-bottom: 1px solid black; width: 100px;">PAYER</td> </tr> <tr> <td>54828</td> <td>Highmark West Virginia</td> </tr> </table>	VALUE	PAYER	54828	Highmark West Virginia
VALUE	PAYER					
54828	Highmark West Virginia					
GS03	Application Receiver's Code	The receiver's Highmark WV-assigned Trading Partner Number will be used, with a prefix of B or R as follows: B = batch mode response was requested. R = real-time response was requested.				
GS06	Group Control Number	Highmark WV 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
NM 108	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 payers 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 West Virginia 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 West Virginia’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 West Virginia

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

- Highmark West Virginia - 54828
(Includes Highmark West Virginia Indemnity, Preferred Provider Organization PPO, Point of Service POS, Comprehensive Major Medical CMM, Major Medical, Medicare Supplemental)

Additional Payers

Highmark Health Insurance Company (HHIC), see Appendix A.

13.1 General Instructions and Guidelines for 270 and 271

13.1.1 Highmark West Virginia Requirements

In some instances Highmark West Virginia'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 West Virginia 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 West Virginia 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 West Virginia will also provide general benefit information for Patient Responsibility, Co-pay, 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 West Virginia also provides the remaining balances for the deductible, co-pay and out of pocket benefits.

13.1.5 Allowable Time Frames for Inquiries

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

13.1 .10 Specific Service Code Request

Highmark West Virginia 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 NM 1.
- 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 West Virginia 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 West Virginia must be listed as the payer by submitting Highmark West Virginia 's NAIC code of 54828 in the GS03 Application Receiver's Code and the loop 2100A NM109 Information Source ID. Highmark West Virginia 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 West Virginia 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 West Virginia's implementation of the 270 transaction.

Segment: **GS** Functional Group Header

Loop:

4010 IG Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note
GS02 Partner	Application	Use the sender's Highmark West Virginia -assigned Trading
	Sender's Code	Number will be used, with a prefix of B or R as follows: B = requesting batch mode response. R = requesting real-time response. The submitted value must not include leading zeros.
GS03	Application Receiver's Code	Submit the Receiver's NAIC code value: 54828 - Highmark West Virginia

GS06 Group Control Number Highmark WV 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 not applicable to Highmark West Virginia products.
BHT06	Transaction Type Code	This data element applies to Medicaid and should not be used for Highmark West Virginia 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 West Virginia does not require this element.
NM108	Identification Code Qualifier	Enter code value "NI", NAIC Identification
NM109	Information Source Primary Identifier	Enter NAIC code value: 54828 - Highmark West Virginia

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

Ref Des.	Element Name	Element Note
NM 101	Entity Identifier Code	Highmark WV business practices do not allow for eligibility inquiries from Third Party Administrators, Employers or Plan Sponsors.
NM 108	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**

21 00D

4010 IG Page: 71/114**Data Element Summary**

Ref Des.	Element Name	Element Note
NM 108	Identification Code Qualifier	Enter code value "MI" Member Identification Number.
NM 109	Identification Code	Enter the full Unique Member ID including the alpha prefix found on the patient's healthcare ID card.

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

Loop: 2100C

21 00D

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 West Virginia identify the patient. 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 WV'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 WV will not use this code. We will respond based on information on our Database.
EQ04	Insurance Type Code	Highmark WV will not use this code.

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

Loop: 2115C

2115D

4010 IG Page: 101

Note: Highmark West Virginia 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 West Virginia’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: <u>VALUE PAYER</u> 54828 Highmark West Virginia
GS03	Application Receiver’s Code	The receiver’s Highmark WV-assigned Trading Partner Number will be used with a prefix of B or R as follows: B = batch mode response was requested. R = real-time response was requested.
GS06	Group Control Number	Highmark WV will send unique control numbers for each functional group.

NM 1 Information Receiver Name

Loop: 2100B

4010 IG Page: 178

Data Element Summary

Ref Des.	Element Name	Element Note
NM 108	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

21 00D

4010 IG Page: 193 / 271

Data Element Summary

Ref Des.	Element Name	Element Note
NM 108	Identification Code Qualifier	“MI” Member Identification Number
NM 109	Identification Code	If a contract ID that is not an Unique Member ID (UMI) or Unique Subscriber ID (USI) is submitted, Highmark West Virginia 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

21 00D

4010 IG Page: 200

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

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

Loop: 2100C

21 00D

4010 IG Page: 201

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

Segment: DTP Subscriber/Dependent Date

Loop: 2100C

21 00D

4010 IG Page: 216, 293

Note: Date that is applicable to all Subscriber/Dependent Eligibility or Benefit Information (211 0C/2 11 0D) 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

211 0D

4010 IG Page: 238, 315

Note: Highmark West Virginia 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

211 0D

4010 IG Page: 240, 317

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

Highmark West Virginia 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

211 0D

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 West Virginia

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

- Highmark West Virginia - 54828
(includes Highmark West Virginia Blue Shield Comp Select, Highmark West Virginia Indemnity, Preferred Provider Organization PPO, Point of Service POS, Health Maintenance Organization HMO, Comprehensive Major Medical CMM, Major Medical and Medicare Supplemental.)

14.1 General Information and Guidelines for Submitting a 278

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

Highmark West Virginia'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 West Virginia 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 West Virginia'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 West Virginia 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 West Virginia must be listed as the payer by submitting Highmark West Virginia's NAIC code of 54828 in the GS03 Application Receiver's Code and the loop 2010A NM109 UMO ID. Highmark West Virginia 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 West Virginia response.

14.2 Data Detail Instructions

This section includes specific comments and directions for Highmark West Virginia'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 West Virginia -assigned Trading Partner Number, with a prefix of R or B: R = requesting real-time response B = requesting batch mode response The submitted value must not include leading zeros.
GS03	Application Receiver's Code	To support Highmark West Virginia'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 West Virginia's NAIC Code is 54828.
GS06	Group Control Number	Highmark WV 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
NM 108	Identification Code Qualifier	Enter code value “PI” - Payor Identification.
NM 109	Identification Code 54828 (Highmark West Virginia NAIC Code)	

Segment: N3 Requester Address

Loop: 2010B

4010 IG Page: 65

Note: Due to Highmark West Virginia’s business practices, this information is needed to identify the requester’s Practice, Physician, Supplier, or Institution office location. If Highmark West Virginia is unable to identify the location, the default will be the main location on the Highmark West Virginia system.

Segment: N4 Requester City/State/Zip Code

Loop: 2010B

4010 IG Page: 66

Note: Due to Highmark West Virginia’s business practices, this information is needed to identify the requester’s Practice, Physician, Supplier, or Institution office location. If Highmark West Virginia is unable to identify the location, the default will be the main location on the Highmark West Virginia system.

Segment: PER Requester Contact Information

Loop: 2010B

4010 IG Page: 68

Data Element Summary

RefDes.	Element	Name Element Note
PER02	Name	Due to Highmark WV’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 WV'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**

RefDes.	Element	Name Element Note
PWK02	Attachment Transmission Code	Due to Highmark WV'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
NM 103	Subscriber/ Dependent Last Name	Due to Highmark WV's business practices, this information is needed to process authorizations.
NM 104	Subscriber/ Dependent First Name	Due to Highmark WV's business practices, this information is needed to process authorizations.
NM 105	Subscriber/ Dependent Middle Name	Due to Highmark WV'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 WV’s business practices, this information is needed to process authorizations.

Data Element Summary

RefDes.	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 WV’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 WV’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 WV’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 WV’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 WV’s business practices, this information is needed to process authorizations.

Data Element Summary

RefDes.	Element	Name Element Note
PER02	Name	Please enter the name of the person Highmark WV 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 West Virginia 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 WV's business practices, this information is needed to process authorizations.
UM04	Health Care Service Location Information	Due to Highmark WV'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: 03 - Emergency U - Urgent.

Segment: **HI** Procedures

Loop: 2000F

4010 IG Page: 159

Data Element Summary

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

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 West Virginia will send the NAIC code for the Utilization Management Organization (UMO) that is sending this response: <u>VALUE PAYER</u> 54828 Highmark West Virginia
GS03	Application Receiver's Code	Highmark WV's Trading Partner Number assigned to the receiver will be used with a prefix of R or B: R = real-time response was requested, B = batch mode response was requested.
GS06	Group Control Number	Highmark WV will send unique control numbers for each functional group.

Appendix Highmark Health Insurance A Company (HHIC)

Highmark West Virginia EDI will accept/send the following transactions for Highmark Health Insurance Company (HHIC):

- Professional Claim (837P)
- Institutional Claim (837I)
- Functional Acknowledgment (997)
- Claim Acknowledgment (277CA)
- Claim Payment Advice (835)
- Eligibility Request and Response (270 and 271)
- Claim Status (276 and 277)

HHIC members can be identified by their Member Identification Cards.

These EDI transactions are supported in both batch and real-time. Guidelines for HHIC transactions and EDI envelopes are identical to guidelines for Highmark West Virginia EDI with the following exceptions:

1. Trading Partner ID

In order to conduct HHIC transactions, Trading Partners must obtain a unique HHIC Trading Partner ID, and use that ID in all transactions and envelopes in place of their Highmark West Virginia Trading Partner ID. Authorization Process instructions in Chapter 4 of this Reference Guide also apply for obtaining an HHIC Trading Partner ID.

For envelopes and transactions being sent to HHIC, the HHIC Trading Partner ID must be used in:

- GS Functional Group Header - GS02 Application Sender's Code
- 837P Professional Claim - Loop 1000A NM 109 Submitter Identifier
- 837I Institutional Claim - Loop 1000A NM 109 Submitter Identifier
- 276 Claim Status Request - Loop 2100B NM 109 Information Receiver ID

For envelopes and transactions being sent by HHIC, the HHIC Trading Partner ID will be placed in:

- GS Functional Group Header - GS03 Application Receiver's Code
- 277 Claim Acknowledgement - Loop 2000B NM 109 Information Receiver ID
- 277 Claim Status Response - Loop 2100B NM109 Information Receiver ID
- 835 Claim Remittance - Transaction Header REF02 Receiver ID

2. Logon ID

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

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

3. HHIC Receiver/Sender/Payer ID

For envelopes and transactions being sent to HHIC, HHIC's NAIC number 71768, 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 NM 109 Receiver Primary ID, and Loop 2010 BC NM 109 Payer ID
- 270 Eligibility Request – Loop 2100A Information Source Primary ID
- 276 Claim Status Request – Loop 2100A Payer ID

For envelopes and transactions being sent by HHIC, HHIC's NAIC number, 71768, 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 NM 109 Payer ID
 - 277 Claim Status Response – Loop 2100A NM 109 Payer ID
-

- 835 Claim Payment Advice – Loop 1000A REF02 Additional Payer ID
- 271 Eligibility Response – Loop 2100A NM109 Information Source Primary ID

