Highmark West Virginia

Standard Companion Guide

Instructions related to Provider Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 1.0

February 1, 2011

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Preface

This Companion Guide (CG) contains two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for Highmark West Virginia or Highmark Health Insurance Company (HHIC) while ensuring compliance with the associated ASC X12 Implementation Guide (IG).

The Communications/Connectivity component is included in the CG to convey the information needed to commence and maintain communication exchange with Highmark West Virginia or HHIC.

The Transaction Instruction component is included in the CG to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

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Highmark West Virginia

Communications/Connectivity

February 1, 2011

Communications/Connectivity Information (CCI)

1. Communications/Connectivity Introduction

1.1 Scope

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

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

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

1.2 Overview

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

- Getting Started: This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.

- Transaction Testing: This section includes detailed transaction testing information as well as other relevant information needed to complete transaction testing with Highmark West Virginia or HHIC .

- Connectivity/Communications: This section includes information on Highmark West Virginia or HHIC's transmission procedures as well as communication and security protocols.

- Contact Information: This section includes telephone and fax numbers for Highmark West Virginia or HHIC's EDI support.

- Control Segments/Envelopes: This section contains information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to Highmark West Virginia or HHIC.

- Acknowledgments and Reports: This section contains information on all transaction acknowledgments sent by Highmark West Virginia or HHIC. These include the TA1, Health Care Claim Acknowledgment (277CA) and An Implementation Acknowledgment for Health Care Insurance (999).

- CCI Change Summary: This section lists the changes made to this companion guide since the last version

- CCI Additional Information: This section contains links to Highmark West Virginia or HHIC's Trading Partner Agreements and Other Resources

1.3 References

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 Companion guidelines for development of the EDI transactions. This document may be accessed by clicking on the following link:

https://www.highmark.com/edi-wv/pdfs/5010providerguide.pdf

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

http://www.wpc-edi.com

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

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221 Health Care Claim Payment/Advice (835))
- Claim Status Category Codes and Claim Status Codes (005010X212 Health Care Claim Status Request and Response (276/277))
- Provider Taxonomy Codes (ASC X12N/005010X222 Health Care Claim: Professional (837P) and ASC X12N/005010X223 Health Care Claim: Institutional (837I))
- Health Care Services Decision Reason Codes (ASC X12N/005010X217 (278))

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working Together

System Operating Hours

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

Provider Data Services

To obtain the status of a provider's application for participation with any Highmark West Virginia or HHIC 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 or HHIC networks; provider data for other payers mentioned in this guide for EDI transactions must be communicated as established by those other payers.

Audit Procedures

The Trading Partner ensures that input documents and medical records are available for every automated claim for audit purposes. Highmark West Virginia or HHIC 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 or HHIC may request, and the Trading Partner is obligated to provide, access to the records at any time.

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

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

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

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

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

Confidentiality

Highmark West Virginia or HHIC and their Trading Partners will comply with the privacy standards for all EDI transactions as outlined in the Highmark West Virginia or HHIC EDI Trading Partner Agreement.

Authorized Release of Information

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

2.2 Trading Partner Registration

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

While Highmark West Virginia or HHIC 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 and HHIC have 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. In order to conduct HHIC transactions, Trading Partners must obtain a unique Trading Partner ID and use that ID in all transactions and envelopes in place of their Highmark West Virginia Trading Partner ID.

- Once the agreement is received, the Trading Partner will be sent a logon ID and password combination for use when accessing Highmark West Virginia or HHIC's EDI system for submission or retrieval of transactions. This ID is also used within EDI Interchanges as the ID of the Trading Partner.

Maintenance of the ID and password by the Trading Partner is detailed in the security section of this document.

Authorization Process

New Trading Partners wishing to submit EDI transactions must submit an EDI Transaction Application to Highmark West Virginia and/or HHIC 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 or HHIC for the submission of EDI transactions. This form must be completed by an authorized representative of the organization.

Highmark West Virginia or HHIC 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.

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 or HHIC's EDI Trading Partner Agreement.

The Highmark West Virginia EDI Transaction Applications and all other EDI request forms are available through the following link:

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

The HHIC EDI Transaction Applications and all other EDI request forms are available through the following link:

https://www.highmark.com/edi-hhic/index.shtml

Highmark West Virginia NAIC 54828 Receiving ASC X12/005010X221 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)
If you are not currently receiving Health Care Claim Payment/Advice (835) remittance transactions generated from the payment cycle in a batch process and wish to, please click on the link below and choose, "Update ERA Status on an Existing Provider".

Adding a New Provider to an Existing Trading Partner

Trading Partners currently using electronic claim submission who wish to add a new provider to their Trading Partner Number should click on the link below and choose, "Add Provider to Existing Trading Partner".

Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should click on the link below and choose, "Delete Provider from Existing Trading Partner".

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

Reporting Changes in Status

Trading Partners changing their information must inform EDI Operations by clicking the link below and providing all information that is to be updated.

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

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.

HHIC NAIC 71768 Receiving ASC X12/005010X221 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)
If you are not currently receiving Health Care Claim Payment/Advice (835) remittance transactions generated from the payment cycle in a

batch process and wish to, please click on the link below and choose, “Update ERA Status on an Existing Provider”.

Adding a New Provider to an Existing Trading Partner

Trading Partners currently using electronic claim submission who wish to add a new provider to their Trading Partner Number should click on the link below and choose, “Add Provider to Existing Trading Partner”.

Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should click on the link below and choose, “Delete Provider from Existing Trading Partner”.

Reporting Changes in Status

Trading Partners changing their information must inform EDI Operations by clicking the link below and provide all information that is to be updated.

https://www.highmark.com/edi-hhic/update/index.shtml

Out of State Providers

Due to an operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association, HHIC cannot accept electronic transactions from out of state nonparticipating/out-of-network providers for HHIC members. Out of State Providers should submit all Medicare Advantage 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.

2.3 Certification and Testing Overview

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

Testing Policy

All Trading Partners must be approved to submit 5010 transactions. Practice Management Software (PMS) Vendors may test their software for 5010 readiness on behalf of all of their clients. After a PMS Vendor has been tested and approved by Highmark WV, any Trading Partner that uses their software may submit a request for

production 5010 access. If a software vendor has not tested and been approved a Trading Partner can do their own testing.

Web Based

Highmark WV offers Web-based syntax and validation testing using a Highmark-customized version of Foresight Corporation's Community Manager® product. Web-based testing is available for claims where the Interchange Receiver ID (ISA08) is Highmark West Virginia (54828) or HHIC (71768). This testing includes the following types of edits:

- Transaction syntax testing (5010 transaction standards),
- HIPAA data requirements testing (5010 Implementation Guides),
- Front-end acceptance (payer) business rules.

This Web-based testing is available free of charge to our Trading Partners who have submitted a request to update to 5010. This functionality is designed to make EDI HIPAA syntax and validation testing for Highmark WV 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.tibco.com.

To get started, you need a Highmark WV Trading Partner ID. This requires completion of an EDI Transaction Application and execution of an EDI Trading Partner Agreement as explained in section 2.2. The Transaction Application includes a place to request access to the Web based testing function.

Highmark West Virginia Transactional Testing

Highmark West Virginia does not allow Trading Partners to connect and send test batch transaction files in our production environment. A rejected 999 will be generated for any transaction file that has "test" indicated in the ISA segment.

Real-Time Electronic Claim[1] Estimation Demonstration Process

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

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

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- An Implementation Acknowledgment for Health Care Insurance (999) transaction will be returned in the event that a rejection occurs at the X12 syntax editing level.

- A Health Care Claim Acknowledgment (277CA) transaction will be returned in the event that a rejection occurs as a result of Highmark West Virginia or HHIC business editing. The Health Care Claim Acknowledgment (277CA) transaction will return actual editing results

If the Electronic Claim Estimation transaction passes the X12 syntax and Highmark West Virginia or HHIC business level edits, a real-time Health Care Claim

- Payment/Advice (835) response containing the member's estimated liability and provider's estimated payment will be returned.

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

In order to submit a real-time Electronic Claim[1] Estimation test transaction, the ISA15 value must be equal to a "T". For more information on HTTPS connectivity specifications for demonstration of Electronic Claim[1] Estimation submissions, refer to the Real-Time

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

Claim Adjudication and Estimation Connectivity Specifications located at:

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

3. Testing with the Payer

Trading Partners should submit a test file containing a minimum of 25 test claims. Test files should contain claims that accurately represent the type of claims that will be submitted in production (ex. Taxonomy/specialty, inpatient, outpatient, member and dependent claims). After a successful test file has been validated through the Community Manager® testing tool, the Trading Partner must request production capabilities by submitting a 5010 production request form to Highmark West Virginia. Upon approval, 5010-ready Practice Management Software Vendors, Clearinghouses and Billing Services will be added to Highmark West Virginia's 5010 approved Trading Partner list.

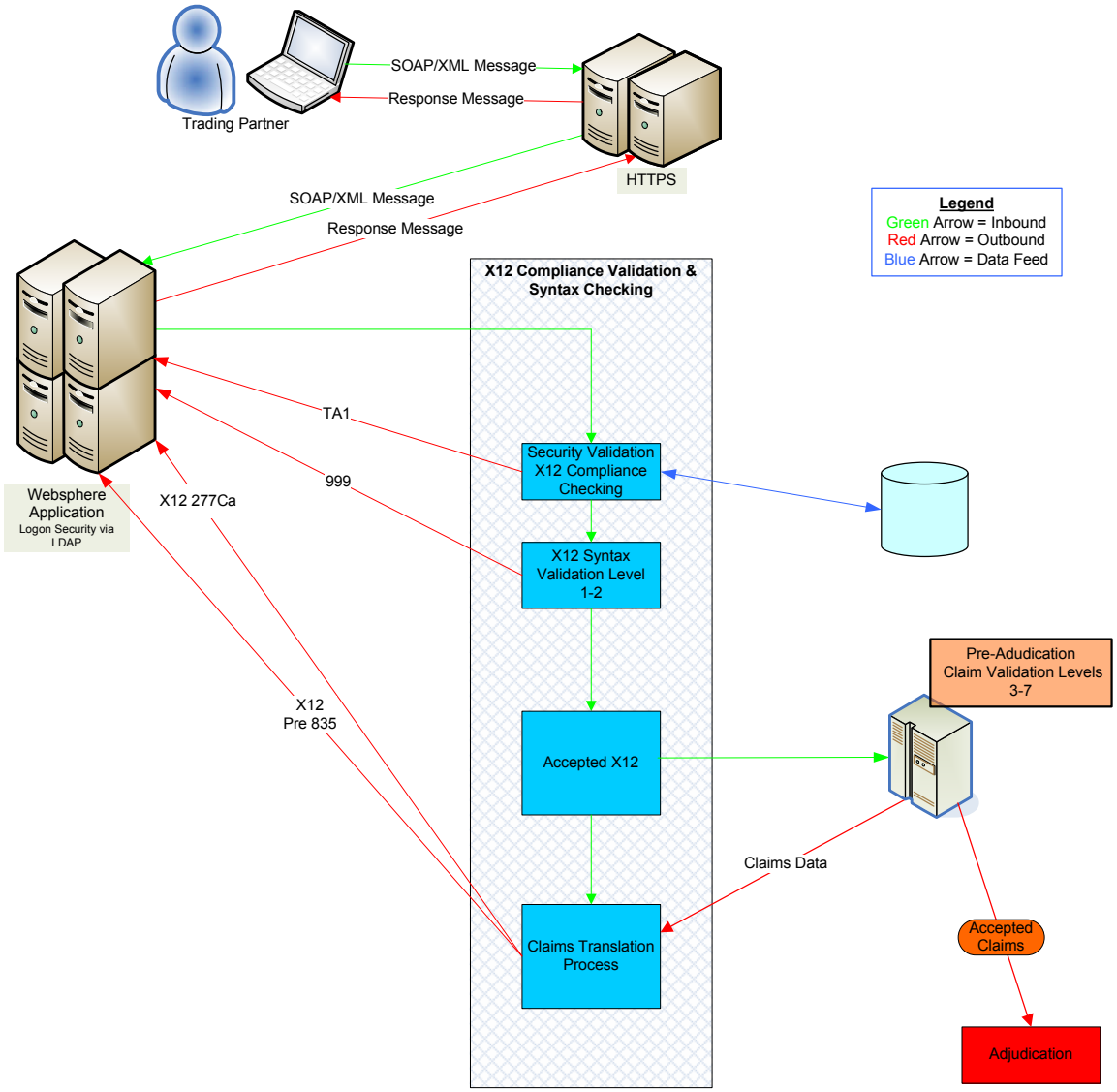
4. Connectivity with the Payer / Communications

Highmark West Virginia or HHIC offers its Trading Partners three types of communication methods for transferring data electronically.

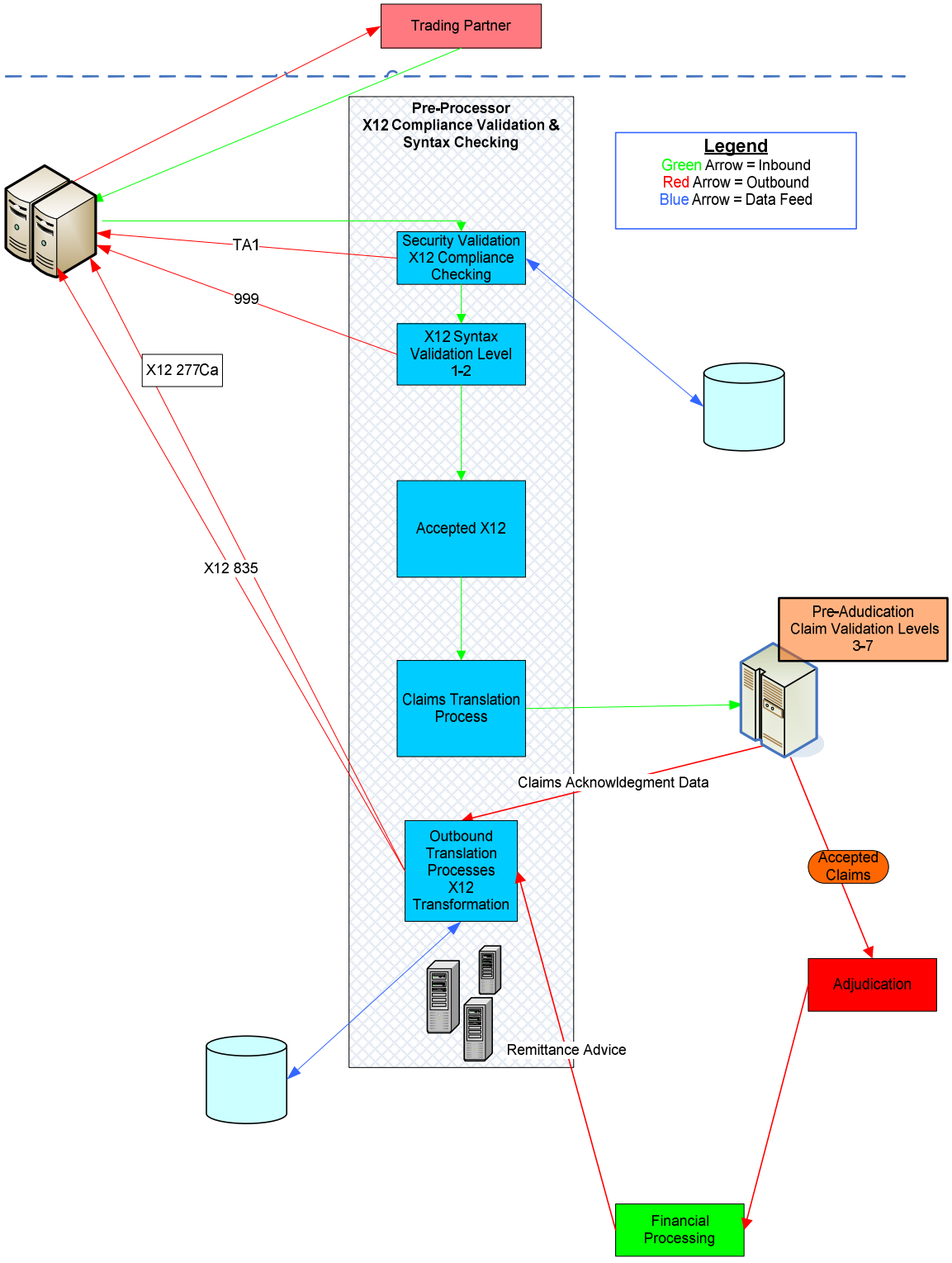
- Dial-up (modem-to-modem) is available for transactions in batch mode.
- File Transfer Protocol (FTP) through a secure Internet connection (eDelivery) is available for transactions in batch mode.
- Hypertext Terminal Protocol Secure (HTTPS) through an Internet web service is available for transactions in real-time mode.

4.1 Process flows

High Level Real Time Transaction Flow



High Level Batch Transaction Flow



4.2 Transmission Administrative Procedures

Real-Time Technical Connectivity Specifications

Highmark West Virginia or HHIC maintains separate specifications detailing the technical internet connectivity requirements for Highmark West Virginia or HHIC's real-time processes. These connectivity specifications can be accessed by clicking on the following link:

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

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

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

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

Real-Time Claim Adjudication and Estimation

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

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

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

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

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

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

5.2.1 - Health Care Claim: Professional (837P)
5.2.2 - Health Care Claim: Institutional (837I))
5.2.3 - Health Care Claim Acknowledgment (277CA)
5.2.4 - Health Care Claim Payment/Advice (835)

4.2.1 Re-transmission procedures

Highmark West Virginia or HHIC do not have specific re-transmission procedures. Submitters can retransmit files at their discretion.

4.3 Communication Protocols

Dial-Up / Asynchronous File Transfer

Trading Partners submitting via modem dial a telephone number and establish a reliable link with Highmark West Virginia or HHIC. 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 or HHIC. 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 or HHIC, you will be required to enter your EDI User Logon ID.

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)
CHPASS	Change Password
L	Logoff

Internet

Highmark West Virginia and HHIC offer two methods to utilize the Internet for conducting electronic business with Highmark West Virginia or HHIC. 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:

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

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

Internet File Transfer Protocol (FTP) through "eDelivery"

The Highmark West Virginia or HHIC 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 or HHIC 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.

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 or HHIC 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.

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

7. Send Highmark West Virginia or HHIC a file. The following is an example of the submission of an electronic claim[1] transaction file:

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

b. Click on the browse button to select a file from your system to send to Highmark West Virginia or HHIC. 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 or HHIC 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 or HHIC. Once completed, the file will appear in your file list.

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

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

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

c. Click on the “ack” directory.

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

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

Highmark West Virginia and HHIC offer a Real-Time Web Service through a secure Internet connection (HTTPS) for our real-time enabled transactions:

- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Claim Status Request/Response 276/277
- Services Review Request for Review/Response (278)
- Claim Adjudication or Estimation and Response Electronic Claim[1] / Health Care Claim Payment/Advice (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 or HHIC, 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 or HHIC's real-time/ SOAP transactions. For instructions on how to program for Highmark West Virginia or HHIC's real-time transactions, refer to the "Real-Time Inquiry Connectivity Specifications" or "Real-Time Claim Adjudication and Estimation Connectivity Specifications" located at the following site:

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

- Complete an EDI Transaction Application
    - Select the real-time transaction option.
    - Include your email address.

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

  - Trading Partner must have a valid Internet enabled 'V' Logon ID. Real-time can be used with any existing 'V' Logon ID.

- Download the Web Services Security Certificate as outlined in appropriate Real-Time Connectivity Specification documents.

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

Inquiry Transactions

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

Claim Adjudication or Estimation Transactions

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

4.4 Security Protocols

Highmark West Virginia or HHIC 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 or HHIC EDI Operations system.

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

Password requirements include:

- Password must be 8 characters in length.
- Password must contain a combination of both numeric and alpha characters.

- Password cannot contain the Logon ID.
- Password must be changed periodically.

5. Contact information

5.1 EDI Customer Service

Contact information for Highmark West Virginia EDI Operations:

Address: EDI Operations
P.O. Box 1948
Parkersburg, WV 26102

TELEPHONE NUMBER:	(304) 424-8828 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. These numbers facilitate the handling of your questions.

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

5.2 EDI Technical Assistance

Contact information for Highmark West Virginia EDI Operations:

Address: EDI Operations
P.O. Box 1948
Parkersburg, WV 26102

TELEPHONE NUMBER:	(304) 424-8828 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.

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

5.3 Provider Service

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

Claims Customer Service – Parkersburg	(888) 809-9121 or (304) 424-7701
Claims Customer Service - Wheeling	(800) 543-7822 or (304) 234-7012
FEP Customer Service - Parkersburg	(800) 535-5266 or (304) 424-7792
HHIC Provider Services	(888) 798-7768
Member Service	(888) 459-4020
TTY (800) 855-1155	

5.4 Applicable websites

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

https://www.highmark.com/edi-wv/pages/guides.shtml

6. Control Segments / Envelopes

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

Note - Highmark West Virginia and HHIC only support 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.

6.1 ISA-IEA

Delimiters

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

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1 E
!	21
“	22
%	25
&	26
‘	27
(	28

Description	Hex value
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	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 or HHIC will use the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, "!", cannot be used in text data (type AN, Sting data element) within the transaction; reference section 2.1 of this document titled Valid Characters in Text Data.

Delimiter Type	Character Used	(hex value)
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	|	(7C)

Data Detail and Explanation of Incoming ISA to Highmark West Virginia or HHIC

Segment: ISA Interchange Control Header (Incoming)

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

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark West Virginia or HHIC can only support code 00 - No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark West Virginia or HHIC can only support code 00 - No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value "ZZ" Mutually Defined to designate a payer-defined ID.
	ISA06	Interchange Sender ID		Use the Highmark West Virginia or HHIC assigned security Login ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33	Use qualifier code value “33”. Highmark West Virginia or HHIC only support the

Loop ID	Reference	Name	Codes	Notes/Comments
				NAIC code to identify the receiver.
	ISA08	Interchange Receiver ID	54828 ----- 71768	Highmark West Virginia --------- HHIC
	ISA14	Acknowledgment Requested		Highmark West Virginia or HHIC do not consider the contents of ISA14. A TA1 segment is returned when the incoming interchange is rejected
	ISA15	Usage Indicator		Highmark West Virginia or HHIC uses the value in this element to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from Highmark West Virginia or HHIC

Segment: ISA Interchange Control Header (Outgoing)

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

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark West Virginia or HHIC can only support code 00 - No Authorization Information present
	ISA02	Authorization Information		This element must be space

Loop ID	Reference	Name	Codes	Notes/Comments
				filled.
	ISA03	Security Information Qualifier	00	Highmark West Virginia or HHIC can only support code 00 - No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	33	Highmark West Virginia or HHIC will send qualifier code value “33” to designate that the NAIC code is used to identify the sender.
	ISA06	Interchange Sender ID	54828 ----- 71768	Highmark West Virginia ––––––– HHIC
	ISA07	Interchange ID Qualifier	ZZ	Highmark West Virginia or HHIC will send qualifier code value “ZZ” Mutually Defined, to designate that a Highmark West Virginia or HHIC - assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The Highmark West Virginia or HHIC-assigned ID will be the trading partner’s security

Loop ID	Reference	Name	Codes	Notes/Comments
				login ID. This ID will be left-justified and space filled.
	ISA14	Acknowledgment Requested		Highmark West Virginia and HHIC always use a 0 (No Interchange Acknowledgement Requested).
	ISA15	Usage Indicator		Highmark West Virginia or HHIC provides T or P as appropriate to identify the test or production nature of all transactions within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS-GE can be found with the related transaction in sections 3 (Instruction Tables) and 5.2 (Payer Specific Rules and Limitations) of the Transaction Information Companion Guide.

6.3 ST-SE

Highmark West Virginia or HHIC has no requirements outside the national transaction implementation guides.

7. Acknowledgments and Reports

7.1 Report Inventory

Highmark West Virginia or HHIC have no proprietary reports.

7.2 ASC X12 Acknowledgments

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance

277 Acknowledgment Claim Acknowledgment to the Electronic Claim[1]

Outgoing Interchange Acknowledgment TA1 Segment

Highmark West Virginia or HHIC return 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 or HHIC TA1 will have an Interchange control envelope (ISA - IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

Highmark West Virginia or HHIC return an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode. In real-time mode, a rejected Implementation Acknowledgment for Health Care Insurance (999) is returned only when the applicable real-time response transaction cannot be returned due to rejections at this level. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Transaction accepted/rejected status is indicated in IK501. For details on this transaction, please refer to the Implementation Acknowledgment for Health Care Insurance (999) in sections 3.8 and 5.2.8 of the Transaction Information Companion Guide.

Outgoing Claim Acknowledgment (277CA Transaction)

The Claim Acknowledgment Transaction is used to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the electronic claim[1] transaction in batch mode. The Health Care Claim Acknowledgement (277CA) is used within the real-time claim process for certain situations when a real-time Health Care Claim

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

Payment/Advice (835) response could not be generated. Acceptance at this level is based on the electronic claim[1] Implementation Guides and front-end edits, and will apply to individual claims within an electronic claim[1] transaction. For those claims not accepted, the Health Care Claim Acknowledgement (277CA) will detail additional actions required of the submitter in order to correct and resubmit those claims. For details on this transaction, please refer to the Health Care Claim Acknowledgement (277CA) in sections 3.3 and 5.2.3 of the Transaction Information Companion Guide.

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Highmark West Virginia

Standard Companion Guide

Transaction Information

February 1, 2011

Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard
HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content (Section 1), example (Sections 2 and 3) or Appendix (Section 4) information contained in the implementation guide.
- Modifying any requirements; including loop, segment or element names, notes or rules, examples, appendix, or code list subsets from Section 2

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2. Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X222	Health Care Claim: Professional
005010X223A1	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010X221	Health Care Claim Payment/ Advice
005010X212	Health Care Claim Status Request and Response
005010X279	Health Care Eligibility Benefit Inquiry and Response
005010X217	Health Care Services Review-Request for Review and Response
005010X231	Implementation Acknowledgment for Health Care Insurance

Highmark West Virginia or HHIC will support all listed transactions in both batch and real-time.

3. Instruction Tables

The instruction tables contain a row for each segment where Highmark West Virginia or HHIC has something additional to convey.

In addition to the row for each segment, one or more additional rows are used to describe Highmark West Virginia or HHIC's usage for composite and simple data elements and for any other information.

Legend
SHADED rows represent “segments” in the X12N implementation guide
NON-SHADED rows represent “data elements” in the X12N implementation guide.
“Loop – specific” comments are indicated in the first segment of the loop.

3.1 005010X222 Health Care Claim: Professional (837P)

Refer to section 5.2.1 for Highmark West Virginia or HHIC Business Rules and Limitations

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark West Virginia or HHIC assigned Trading Partner Number. The submitted value must not include leading zeros. For real-time claim adjudication or estimation, add a prefix of "R" to the Trading Partner number. For more information on how to distinguish the type of real-time 837, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' found on the following link: https://www.highmark.com/edi-wv/pdfs/rtguide.pdf
	GS03	Application Receiver's Code	54828 ---------- 71768	Highmark West Virginia ---------- HHIC
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Highmark West Virginia or HHIC assigned Trading Partner Number. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		Highmark West Virginia or HHIC will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		Highmark West Virginia or HHIC

Loop ID	Reference	Name	Codes	Notes/Comments
	NM109	Receiver Primary Identifier	54828 71768	Identifies Highmark West Virginia as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. Identifies HHIC as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark West Virginia or HHIC-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 or HHIC.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	N3	Billing Provider Address		The provider's address on Highmark West Virginia's internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on Highmark West Virginia's internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		Highmark West Virginia or HHIC will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on Highmark West Virginia's internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		

Loop ID	Reference	Name	Codes	Notes/Comments
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BA	N4	Subscriber City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Subscriber's city, state and zip, send the Billing Provider address information as the default.
2010BA	REF	Subscriber Secondary Identification		Highmark West Virginia or HHIC does not need secondary identification to identify the subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		Highmark West Virginia or HHIC
	NM109	Payer Identifier	54828 --- 71768	Highmark West Virginia --- HHIC
2010BB	N4	Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Payer's city, state and zip, send the Billing Provider address information as the default.
2010BB	REF	Payer Secondary Identification		Highmark West Virginia or HHIC does not need secondary identification to identify the payer.
2300	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	PWK	Claim Supplemental Information		**1.** Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark West Virginia or HHIC's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. **2**. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. **3**. A Claim Attachment Fax 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. To access the cover sheet, please click on the link below: https://www.highmark.com/edi-wv/pdfs/pwksheet.pdf **4**. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

Loop ID	Reference	Name	Codes	Notes/Comments
	PWK01	Attachment Type Code		Highmark West Virginia or HHIC may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.
	PWK02	Attachment Transmission Code	AA (Available on Request) ---------- BM (By mail) ---------- FX (By fax)	Highmark West Virginia or HHIC's business practices and policy only support the listed transmission types at this time. ---------- mail to: Highmark West Virginia Attachments, PO Box 7026, Wheeling, WV 26003-0766 ---------- fax to (304) 234-7086
2300	NTE	Claim Note		For fastest processing of anesthesia claims where the surgery procedure code reported in the Anesthesia Related Procedure HI segment is a Not Otherwise Classified code, report a complete description of the surgical services in this NTE segment.
2300	CR2	Spinal Manipulation Information		This segment is not needed for the payer's adjudication process; therefore, the segment is not required.
2300	CRC	Patient Condition Information: Vision		This segment is not needed for the payer's adjudication process; therefore, the segment is not required.
2300	HI	Health Care Diagnosis Code		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Anesthesia Related procedure		On claims reporting a Not Otherwise Specified or a Not Otherwise Classified anesthesia code on the service line, Highmark West Virginia or HHIC requires that the related surgery or other services code(s) be reported. If the only applicable code is a Not Otherwise Classified code, a description of the surgery or other services must be reported in the Procedure Code Description SV101-7.

Loop ID	Reference	Name	Codes	Notes/Comments
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark West Virginia or HHIC-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 or HHIC.
2310C	NM1	Service Facility Location	21 (Inpatient Hospital) 31 (Skilled Nursing Facility) 51 (Inpatient Psychiatric Facility) 55 (Residential Substance Abuse Treatment Facility) 61 (Comprehensive Inpatient Rehabilitation Facility)	For this list of Places of Service (Loop 2300, CLM05-1 and/or 2400 SV105), the services were performed inpatient in a facility. Therefore by definition the location of the services cannot be the same as the Billing Provider's address, and the service location must be submitted in this loop.
2310C	N4	Service Facility Location City/State/Zip		
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2330A	N4	Other Subscriber City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Other Subscriber's city, state and zip, send the Billing Provider address information as the default.
2330B	NM1	Other Payer Name		

Loop ID	Reference	Name	Codes	Notes/Comments
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2330B	N4	Other Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Other Payer's city, state and zip, send the Billing Provider address information as the default.
2400	SV1	Service Line		
	SV101-1	Product / Service ID Qualifier		1) Qualifier value HC, HCPCS, is the only value Highmark West Virginia or HHIC will accept in this element.

Loop ID	Reference	Name	Codes	Notes/Comments
	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	AA AD GC QK QX QY 47 ---------- QZ ---------- QX QZ ---------- AA AD GC QK QY 47	For anesthesia services where the billing provider is not a Certified Registered Nurse Anesthetist (CRNA), Highmark West Virginia or HHIC requires submission of one of the listed anesthesia certification modifiers. ---------- If the billing provider is not participating and is not in West Virginia, code value QZ is also valid. ---------- For anesthesia services where the billing provider is a CRNA, Highmark West Virginia or HHIC requires submission of one of the listed anesthesia certification modifiers. ---------- If the billing provider is not participating and not in West Virginia, code values are also valid.
	SV103	Unit / Basis for Measurement Code		Anesthesia CPT codes (00100-01999) must be reported with minutes, except code 01996 which is reported with units indicating the number of days managing continuous drug administration. Moderate (Conscious) Sedation Codes 99143 - 99145 and 99148 - 99150, and anesthesia modifying unit procedure codes 99110, 99116, 99135, 99140 are reported with UN, Units and not MJ, Minutes.

Loop ID	Reference	Name	Codes	Notes/Comments
2400	PWK	Line Supplemental Information		**1**. Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark West Virginia or HHIC's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. **2**. The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. **3.** A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. To access the cover sheet, please click on the link below: https://www.highmark.com/edi-wv/pdfs/pwksheet.pdf **4**. Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

Loop ID	Reference	Name	Codes	Notes/Comments
	PWK01	Attachment Type Code		Highmark West Virginia or HHIC may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.
	PWK02	Attachment Transmission Code	AA (Available on Request) --------- BM (By mail) --------- FX (By fax)	Highmark West Virginia or HHIC's business practices and policy only support the listed transmission types at this time. --------- mail to: Highmark West Virginia Attachments, PO Box 7026, Wheeling, WV 26003-0766 --------- fax to (304) 234-7086
2400	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.
2400	AMT	Sales Tax Amount		This amount is not needed for the payer's adjudication process; therefore, the amount is not required.
2400	PS1	Purchase Service Information		This information is not needed for the payer's adjudication process; therefore, it is not required.
2410	LIN	Drug Identification		**1.** NDC codes are required when specified in the Provider's agreement with Highmark West Virginia or HHIC. **2.** Highmark West Virginia and HHIC encourage submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark West Virginia or HHIC-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 or HHIC.

Loop ID	Reference	Name	Codes	Notes/Comments
2420E	N4	Ordering Provider City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Ordering Provider's city, state and zip, send the Billing Provider address information as default values.

3.2 005010X223A1 Health Care Claim: Institutional (837I)

Refer to section 5.2.2 for Highmark West Virginia or HHIC Business Rules and Limitations

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's Highmark West Virginia or HHIC assigned Trading Partner Number. The submitted value must not include leading zeros. For real-time claim adjudication or estimation, add a prefix of "R" to the Trading Partner number. For more information on how to distinguish the type of real-time 837, see the 'Real-Time Claim Adjudication and Estimation Connectivity Specifications' by clicking on the following link: https://www.highmark.com/edi-wv/pdfs/rtguide.pdf
	GS03	Application Receiver's Code	54828 ---------- 71768	Highmark West Virginia (Plan Code 443). ---------- HHIC (Plan Code 377).
	GS08	Version/Release / Industry Identifier Code		Use 005010X223A1
	ST	Transaction Set Header		
	ST03	Version/Release / Industry Identifier Code		Use 005010X223A1

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's Highmark West Virginia or HHIC assigned Trading Partner Number. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		Highmark West Virginia or HHIC will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		Highmark West Virginia or HHIC
	NM109	Receiver Primary Identifier	54828 --- 71768	Identifies Highmark West Virginia as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID. --- Identifies HHIC as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark West Virginia or HHIC-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 or HHIC.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	N3	Billing Provider Address		The provider's address on Highmark West Virginia's internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on Highmark West Virginia's internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.

Loop ID	Reference	Name	Codes	Notes/Comments
2100AA	PER	Billing Provider Contact Information		Highmark West Virginia or HHIC will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on Highmark West Virginia's internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BA	N4	Subscriber City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Subscriber's city, state and zip, send the Billing Provider address information as the default.
2010BA	REF	Subscriber Secondary Identification		Highmark West Virginia or HHIC does not need secondary identification to identify the subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		Highmark West Virginia or HHIC
	NM109	Payer Identifier	54828 --- 71768	Facility billing Highmark West Virginia --- Facility billing HHIC
2010BB	N4	Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Payer's city, state and zip, send the Billing Provider address information as the default.

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

Loop ID	Reference	Name	Codes	Notes/Comments
2300	PWK	Claim Supplemental Information		**1.** Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark West Virginia or HHIC 's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. **2.** The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. **3.** A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. To access the cover sheet, please click on the link below: https://www.highmark.com/edi-wv/pdfs/pwksheet.pdf **4.** Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

Loop ID	Reference	Name	Codes	Notes/Comments
	PWK01	Attachment Type Code		Highmark West Virginia or HHIC may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.
	PWK02	Attachment Transmission Code	AA (Available on Request) --- BM (By mail) --- FX (By fax)	Highmark West Virginia or HHIC 's business practices and policy only support the listed transmission types at this time. --- Mail to: Highmark West Virginia Attachments, PO Box 7026, Wheeling, WV 26003-0766 --- fax to (304) 234-7086
2300	REF	Payer Claim Control Number		
	REF02	Payer Claim Control Number		Highmark West Virginia or HHIC 's claim number of the previous claim is needed when this claim is a replacement, void or late charge (CLM05-3 value of 5, 7, or 8) related to that previously adjudicated claim.
2300	K3	File Information		Present on Admission (POA) codes are not reported in the K3. Claims with POA codes in the K3 will not be accepted for processing. POA codes are reported in the appropriate HI segment along with the appropriate diagnosis code.
2300	HI	Principal Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Admitting Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI	Patient's Reason for Visit		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future
2300	HI	Other Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future
2300	HI	Principal Procedure Information		ICD-10-PCS Procedure Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future
2300	HI	Other Procedure Information		ICD-10-PCS Procedure Codes will not be accepted at this time. Further information addressing Highmark West Virginia or HHIC's implementation of the ICD-10 mandate will be issued in the future
	HI01-1	Code List Qualifier Code		Until further notification from Highmark West Virginia or HHIC, Advanced Billing Concepts (ABC) codes will not be accepted.
2300	HI	Occurrence Information		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.
2310A	PRV	Attending Provider Specialty Information		When the Attending Provider's National Provider Identifier (NPI) is associated with more than one Highmark West Virginia or HHIC - 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.
2310E	N4	Service Facility Location City/State/Zip		

Loop ID	Reference	Name	Codes	Notes/Comments
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.
2330A	N4	Other Subscriber City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Other Subscriber's city, state and zip, send the Billing Provider address information as the default.
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2330B	N4	Other Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state and zip information. If the paired N3 is not sent, and the submitter does not know the Other Payer's city, state and zip, send the Billing Provider address information as the default.

Loop ID	Reference	Name	Codes	Notes/Comments
2400	PWK	Line Supplemental Information		**1.** Attachments associated with a PWK paperwork segment should be sent at the same time the 837 claim transaction is sent. Highmark West Virginia or HHIC's business practice is that additional documentation received more than 5 days after the receipt of your 837 claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim. **2.** The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK. **3.** A PWK Supplemental Claim Information Cover Sheet must be used when faxing or mailing supplemental information in support of an electronic claim. The Attachment Control Number on this cover sheet must match the control number submitted in the PWK06 data element. That control number is assigned by the provider or the provider's system. To access the cover sheet, please click on the link below: https://www.highmark.com/edi-wv/pdfs/pwksheet.pdf **4.** Submission of attachments, when necessary for claim adjudication, should be limited to 837 claim submissions in batch mode. Real-time claims submitted with the indication of attachments will be moved to batch processing.

Loop ID	Reference	Name	Codes	Notes/Comments
	PWK01	Attachment Type Code		Highmark West Virginia or HHIC may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.
	PWK02	Attachment Transmission Code	AA (Available on Request) --- BM (By mail) --- FX (By fax)	Highmark West Virginia or HHIC's business practices and policy only support the listed transmission types at this time. --- Mail: Highmark West Virginia Attachments, PO Box 7026, Wheeling, WV 26003-0766 --- fax to: (304) 234-7086

3.3 005010X214 Health Care Claim Acknowledgment (277CA)

Refer to section 5.2.3 for Highmark West Virginia or HHIC Business Rules and Limitations

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code	54828 --- 71768	This will match the payer id in the GS03 of the claim transaction Highmark West Virginia --- HHIC
	GS03	Application Receiver's Code		This will always be the Highmark West Virginia or HHIC assigned Trading Partner Number for the entity receiving this transaction.
2100A	NM1	Information Source Name		
2100A	NM109	Information Source Identifier	54828 --- 71768	This will match the payer id in the GS03 of the claim transaction Highmark West Virginia --- HHIC

2100B	NM1	Information Receiver Name		
2100B	NM109	Information Receiver Identifier		This will always be the Highmark West Virginia or HHIC assigned Trading Partner Number for the entity that submitted the original 837 transaction.
2200B	STC	Information Receiver Status Information		Status at this level will always acknowledge receipt of the claim transaction by the payer. It does not mean all of the claims have been accepted for processing. We will not report rejected claims at this level.
2200B	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level.
2200B	STC01-2	Health Care Claim Status Code	19	Default value for this status level.
2200B	STC01-3	Entity Identifier Code	PR	Default value for this status level.
2200B	STC03	Action Code	WQ	This element will always be set to WQ to represent Transaction Level acceptance. Claim specific rejections and acceptance will be reported in Loop 2200D.
2200B	STC04	Total Submitted Charges		In most instances this will be the sum of all claim dollars (CLM02) from the 837 being acknowledged. In instances where the claim dollars do not match, an exception process occurred. **Details on exception processes to follow**.
2200C		Provider of Service Information Trace Identifier		The 2200C loop will not be used. Status or claim totals will not be provided at the provider level.
2200D	STC	Claim Level Status Information		Relational edits between claim and line level data will be reported at the service level
2200D	STC01-2	Health Care Claim Status Code	247	Health Care Claim Status Code '247 - Line Information' will be used at the claim level when the reason for the rejection is line specific.

2200D	STC01-2	Health Care Claim Status Code	685	Health Care Claim Status Code '685: Claim could not complete adjudication in Real- Time. Claim will continue processing in a batch mode. Do not resubmit.' will be used for real-time claims that are accepted into the system for adjudication, but not finalized through the real-time 835.
2200D	STC01-2	Health Care Claim Status Code	687	Health Care Claim Status Code '687: Claim estimation cannot be completed in real- time. Do not resubmit' will be used for real-time estimations accepted into the system, but not finalized through the real-time 835.
2200D	DTP	Claim Level Service Date		
2200D	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used.
2200D	DTP03	Claim Service Period		The earliest and latest service line dates will be used as the claim level range date for professional claims. When the service line is a single date of service, the same date will be used for the range date.
2200D	REF	Payer Claim Control Number		This segment will only be returned in a real-time 277 Claim Acknowledgment when a real-time claim (837) was accepted for adjudication, but could not be finalized through the real-time 835. This segment will not be returned for RT estimations This segment will not be returned for claims acknowledged in batch mode
2220D	STC	Service Line Level Status Information		Relational edits between claim and line level data will be reported at the service level
2220D	DTP	Service Line Date		.
2220D	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used

2220D	DTP03	Service Line Date		When the service line date is a single date of service the same date will be used for the range date

3.4 005010X221 Health Care Claim Payment/ Advice (835)

Refer to section 5.2.4 for Highmark West Virginia or HHIC Business Rules and Limitations

Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code	54828 --- 71768	Highmark West Virginia or HHIC will send the NAIC code for the Payer that is sending this transaction. Highmark West Virginia **----------** HHIC
	GS03	Application Receiver's Code		This will always be the Highmark West Virginia or HHIC assigned Trading Partner Number for the entity receiving this transaction.
	BPR	Financial Information		
	BPR01	Transaction Handling Code	H	**RT Estimation and Adjudication use:** This value will always be used in the real-time Health Care Claim Payment/ Advice (835) response since no actual payment is being made.
	BPR02	Total Provider Payment Amount		**RT Adjudication use:** The real-time Health Care Claim Payment/ Advice (835) "payment" amount (BPR02) will equal the claim "payment" amount (CLP04) since this will be a single claim Health Care Claim Payment/ Advice (835). Actual payment for claims adjudicated in real-time will be reported in a batch or payment cycle 835.

	BPR04	Payment Method Code	NON	**RT Estimation and Adjudication use:** This value will always be used in the real-time Health Care Claim Payment/ Advice (835) response since no actual payment is being made or money moved.
	REF	Receiver Identification		
	REF02	Receiver Identification		This will be the electronic Trading Partner Number assigned by Highmark West Virginia or HHIC's EDI Operations for transmission of Health Care Claim Payment/ Advice (835) transactions
1000A	N1	Payer Identification		
1000A	N102	Payer Name	Highmark West Virginia Health Care Account	**Health Care Spending Account use:** This Payer Name will be used to distinguish a Health Care Claim Payment/ Advice (835) that contains claim payments from members' Health Care Spending Accounts. See Section 5.2.4 for more information.
1000A	REF	Additional Payer Identification		
1000A	REF01	Reference Identification Qualifier	NF	This value will always be used.
1000A	REF02	Additional Payer Identification	54828 --- 71768	Highmark West Virginia --- HHIC
1000B	REF	Additional Payee Identification		
1000B	REF01	Additional Payee Identification Qualifier	TJ	The Provider's Tax Identification Number will be sent when the Provider's NPI is sent in the 1000B Payee Identification N104.

2000	LX	Header Number		A number assigned for the purpose of identifying a sorted group of claims.
2000	LX01	Assigned Number	1	All claims except Highmark West Virginia or HHIC Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period.
2000	LX01	Assigned Number	2	Highmark West Virginia or HHIC Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period. Refer to section 5.2.4 of this document for further information.
2100	CLP	Claim Payment Information		
2100	CLP01	Claim Submitter's Identifier		The actual Patient Account Number may not be passed from paper claim submissions.
2100	CLP02	Claim Status Code	2	**Health Care Spending Account use:** This status code will be used on all claims within a Health Care Claim Payment/ Advice (835) that contains claim payments from members' Health Care Spending Accounts. Refer to Section 5.2.4 for more information.
2100	CLP02	Claim Status Code	25	**RT Estimation use:** Highmark West Virginia or HHIC will always use this value for status on a real-time Estimation response.

	CLP04	Claim Payment Amount		**RT Adjudication use:** The real-time Health Care Claim Payment/ Advice (835) Claim 'Payment' Amount (CLP04) will equal the Provider 'Payment' Amount (BPR02) since this will be a single claim Health Care Claim Payment/ Advice (835). **RT Estimation use:** The Claim Payment Amount will always equal 0.
2100	CAS	Claim Adjustment		
2100	CAS01	Claim Adjustment Group Code	OA	**Health Care Spending Account use**: This Group Code will be used for all adjustment dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account. **RT Estimation use:** This Group Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the claim payment amount (CLP04) to 0.
2100	CAS02	Claim Adjustment Reason Code	23	**Health Care Spending Account use:** This Reason Code will be used for all adjustment dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.

			101	**RT Estimation use:** This Reason Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the claim paid amount to 0.
2100	NM1	Crossover Carrier Name		This segment will only be used to report a 'Blue on Blue' Coordination of Benefits coverage situation. In this situation, Highmark West Virginia will indicate the claim has been processed by Highmark West Virginia and is being transferred to a second Highmark West Virginia coverage.
2100	NM1	Corrected Priority Payer Name		
2100	NM108	Identification Code Qualifier	PI	Highmark West Virginia or HHIC will always use this value
2100	NM109	Identification Code		Other payer IDs are not currently retained therefore a default value of 99999 will be used in this element.
2100	REF	Other Claim Related Identification		
2100	REF01	Reference Identification Qualifier	CE	
2100	REF02	Other Claim Related Identifier		Professional claims - This value will be utilized to provide the payer's Class of Contract Code and code description. Institutional claims - This value will be utilized to provide the Reimbursement Method Code.
2110	SVC	Service Payment Information		

2110	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)
2110	SVC03	Line Item Provider Payment Amount		**RT Estimation use:** The Line Item Provider Payment Amount will always equal 0.
2100	CAS	Service Adjustment		
2100	CAS01	Claim Adjustment Group Code	OA	**RT Estimation use:** This Group Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the service paid amount to 0.
2100	CAS02	Claim Adjustment Reason Code	101	**RT Estimation use:** This Reason Code will be used for the adjustment dollars associated with the estimated provider payment amount. This CAS Segment adjustment will bring the service paid amount to 0.
	PLB	Provider Adjustment		
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	CS	This value will be used for financial arrangement adjustments such as Bulk Adjustments, Cost Rate Adjustments, etc. Supporting identification information will be provided in the Reference Identification element.

	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	FB	This value will be used to reflect balance forward refund amounts between weekly Health Care Claim Payment Advice (835) transactions. Refer to Section 5.2.4 for more information.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	L6	This value will be used to reflect the interest paid or refunded for penalties incurred as a result of legislated guidelines for timely claim processing. Refer to Section 5.2.4 for more information on interest related to deferred refunds.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	WO	This value will be used for recouping claim overpayments and reporting offset dollar amounts. Refer to Section 5.2.4 for more information
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Provider Adjustment Reason Code is "FB" the Provider Adjustment Identifier will contain the applicable 835 Identifier as defined in the ASC X12/005010X221 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing

	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Adjustment Reason Code is "WO", the Provider Adjustment Identifier will contain the Highmark West Virginia or HHIC Claim Number for the claim associated to this refund recovery. For Highmark West Virginia or HHIC identified overpayments, the claim number will be followed by the word "DEFER" (example: 06123456789DEFER) when the reversal and correction claims are shown on the current Health Care Claim Payment/ Advice (835) but the refund amount will not be deducted until after the 60 day appeal period Refer to Section 5.2.4 for more information on Claim Overpayment Refunds.

3.5 005010X212 Health Care Claim Status Request and Response (276/277)

This information will be provided at a future date.

3.6 005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271)

This information will be provided at a future date.

3.7 005010X217 Health Care Services Review-Request for Review and Response (278)

This information will be provided at a future date.

3.8 005010X231 Implementation Acknowledgment for Health Care Insurance (999)

Loop ID	Reference	Name	Codes	Notes/Comments
2100	CTX	Segment Context		Highmark West Virginia and HHIC have implemented levels

				1 and 2 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		Highmark West Virginia and HHIC have implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		
	IK404	Copy of Bad Data Element		The 005010 version of the 999 transaction does not support codes for errors in the GS segment, therefore, when there are errors in the submitted GS, "TRADING PARTNER PROFILE" will be placed in this element to indicate that one or more invalid values were submitted in the GS.
2110	CTX	Element Context		Highmark West Virginia and HHIC have implemented levels 1 and 2 edits only. This CTX segment will not be used at this time

4. TI Change Summary

5. TI Additional Information

This section may contain one or more of the following appendices.

5.1 Business Scenarios

No business scenarios at this time.

5.2 Payer Specific Business Rules and Limitations

5.2.1 005010X222 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 Implementation Guide is the primary source for definitions, data usage, and requirements.

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

Virginia or HHIC benefit plans, Federal Employees Health Benefit Plan, and BlueCard Par Point of Service (POS). Accurate reporting of Highmark West Virginia or HHIC's NAIC code is critical for claims submitted to Highmark West Virginia or HHIC EDI.

Additional Payers

Highmark Health Insurance Company (HHIC) Highmark West Virginia contracted providers should submit all HHIC claims to HHIC's NAIC code (71768).

Patient with Coverage from another Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark West Virginia and HHIC to accept Health Care Claim: Professional (837P) claims when the patient has coverage from an out-of-state Plan. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha prefix. Also, Highmark West Virginia or HHIC must be listed as the payer by submitting 54828 for Highmark West Virginia or 71768 for HHIC in the Application Receiver GS03 and in the loop 2010BB NM109 Payer ID. Highmark West Virginia or HHIC 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 of HHIC member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark West Virginia or HHIC'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 and HHIC 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 or HHIC.

Dental Services

Dental services that are reported with CDT dental procedure codes must be submitted as an ASC X12N/005010X224 Health

Care Claim: Dental (837) transaction to Highmark West Virginia and HHIC's dental associate, United Concordia Companies, Inc. (UCCI). Oral surgery services that are reported with CPT medical procedure codes must be submitted as a Health Care Claim: Professional (837P) transaction to Highmark West Virginia, HHIC or UCCI according to which payer is responsible for the patient's oral surgery coverage.

Real-Time Claim Adjudication and Estimation

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

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

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

- Real-Time Electronic Claim[1] Submission Limitations

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

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

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

- Real-time General Requirements and Best Practices

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

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

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

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

Claims Resubmission

Frequency Type codes that tie to "prior claims" or "finalized claims" refer to a previous claim that has completed processing in the payer's system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional

information are not considered a "prior claim" or "finalized claim". An 837 is not an appropriate response to a payer's request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

5.2.2 005010X223 Health Care Claim: Institutional (837I)

Companion guides supplement the national guide and addenda with clarifications and payer-specific usage and content requirements. This section and the corresponding transaction detail make up the companion guide for submitting Health Care Claim: Institutional (837I) claims for patients with Highmark West Virginia or HHIC benefit plans, including Indemnity, Preferred Provider Organization (PPO), Point of Service (POS), Comprehensive Major Medical (CMM), Medicare Advantage, and Medicare Supplemental. Accurate reporting of Highmark West Virginia's NAIC code 54828 or HHIC's NAIC code 71768 along with associated prefixes and suffixes are critical for claims submitted to Highmark West Virginia or HHIC EDI.

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

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross Blue Shield Association allows Highmark West Virginia to accept Health Care Claim: Institutional (837I) claims when the patient has coverage from an out-of-state plan. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha prefix. Also, Highmark West Virginia or HHIC must be listed as the payer by submitting Highmark West Virginia's NAIC code of 54828 or HHIC's NAIC code of 71768 in the GS03 Application Receiver's Code and the loop 2010BB NM109 Payer ID. Highmark West Virginia or HHIC 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 or HHIC member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on Highmark West Virginia or HHIC'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 or HHIC 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 or HHIC.

Transaction Limitations

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

Real-Time Claim Adjudication and Estimation

Highmark West Virginia or HHIC real-time claim adjudication and claim estimation processes leverage the electronic claim[1] transaction. The real-time electronic claim[1] applies the same business rules and edits as the batch electronic claim[1], with the exception of items listed below. Highmark West Virginia and HHIC require that claims submitted for estimation be differentiated from claims submitted for adjudication within the SOAP of the HTTPS transmission protocol. For information on SOAP, connectivity and the related transactions for real-time claim adjudication and estimation requests, see Section 4.2 of the Communication/Connectivity Companion.

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

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

- Real-Time Electronic Claim[1] Submission Limitations

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

- The real-time claim adjudication and estimation submission process is limited to a single claim (1 Loop 2300 - Claim Information) within an Interchange (ISA-IEA). Transmissions with more than a single claim will receive a rejected Implementation Acknowledgment for Health Care Insurance (999).
- Only initial claims can be submitted; not replacement, void, etc.
- Claims for FEP (Federal Employee Program) and Out-of-State Blue Cross Blue Shield may be submitted in real-time; however they will be moved to batch processing.
- Claims submitted with the PWK Segment indicating an attachment is being sent may be submitted in real-time, however they will be moved to batch processing.
- Real-time Health Care Claim: Institutional (837I) submissions are limited to 50 lines per claim.

o Real-time General Requirements and Best Practices

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

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

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

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

Claims Resubmission

Frequency Type codes that tie to "prior claims" or "finalized claims" refer to a previous claim that has completed processing in the payer's system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are

pending due to a request from the payer for additional information are not considered a "prior claim" or "finalized claim". An 837 is not an appropriate response to a payer's request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

5.2.3 005010X214 Health Care Claim Acknowledgment (277CA)

Timeframe for Batch Health Care Claim Acknowledgment (277CA)

Generally, batch claim submitters should expect a Health Care Claim Acknowledgment (277CA) within twenty-four hours after Highmark West Virginia or HHIC receive the electronic claims[1], subject to processing cutoffs. See section 4.3 Communication Protocols of the Communications/Connectivity Companion Guide for information on retrieving the batch Health Care Claim Acknowledgment (277CA).

Real-Time Health Care Claim Acknowledgment (277CA)

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

- Claim adjudication and electronic claim[1] estimation requests that are rejected as a result of data validation and business data editing (i.e. front-end edits).
- Claim adjudication and electronic claim[1] estimation requests accepted through data validation and business editing, but could not be finalized through adjudication/estimation and reported on a real- time

Electronic Claim[1]/ Health Care Claim Payment/Advice (835) response.

RT Claim Adjudication

For claims accepted into the system for adjudication, but not finalized through the real-time Electronic Claim[1]/ Health Care Claim Payment/Advice (835):

- These claims will continue processing in a batch mode and be reported in a daily or weekly batch 'payment cycle Electronic Claim[1]/ Health Care Claim Payment/Advice (835)' when adjudication has been completed.
- The Health Care Claim Acknowledgment (277CA) claim status reported for these claims will be:

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

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

Real-Time Claim Estimation

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

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

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

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

[1] Electronic claim includes both ASC X12N/005010X222 Health Care Claim: Professional (837) and ASC X12N/005010X223A1 Health Care Claim: Institutional (837) unless otherwise noted

For information on connectivity and the related transactions for real- time claim adjudication and estimation, see Section 4.2 of the Communications/Connectivity Companion Guide.

RT General Requirements and Best Practices

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

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

5.2.4 005010X221 Health Care Claim Payment/ Advice (835)

Availability of Payment Cycle 835 Transactions (Batch)

Payment Health Care Claim Payment/Advice (835) transactions are created on a weekly basis. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete, and remain available for 7 days. If a Health Care Claim Payment/Advice (835) transaction was expected but not available for retrieval on the third day after the payment cycle was complete, contact EDI Operations for assistance.

Limitations

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

check does not routinely contain an Explanation of Benefits notice.

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

  Payer name and address

  Payee name and address

Claim Overpayment Refunds

- Member Facility Institutional Claims

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

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

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

Highmark West Virginia and HHIC use the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing

- Professional and Non-member Facility Claims

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

  When overpayment of a professional claim is identified by Highmark West Virginia or HHIC , the provider's payment will not be reduced by the overpayment amount until 60 days after the reversal and correction claims appear on the Health Care Claim Payment/Advice (835). This delay is intended as an opportunity for the provider to appeal Highmark West Virginia or HHIC'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 or HHIC that contain the details of an overpayment.

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

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

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

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

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

- Provider Adjustment Reason Code WO, Overpayment Recovery.

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

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

Highmark West Virginia and HHIC use the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing

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 Health Care Claim Payment/Advice (835) transaction (ST to SE Segment) to document the payment from the member's saving/ spending account. This separate or second Health Care Claim Payment/Advice (835) reporting methodology is termed a "COB reporting model" meaning the member spending account Health Care Claim Payment/Advice (835) will have the code value attributes of a secondary claim payment. This is a Health Care Claim Payment/Advice (835) reporting model or methodology,

designed to utilize existing automated account posting software functionality and is NOT considered to be the same as a true Payer to Payer COB process for claim adjudication. Highmark West Virginia will continue to create a Health Care Claim Payment/Advice (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 Health Care Claim Payment/Advice (835) transaction to document how the remaining liabilities were addressed by the payment from the member's account. The additional Health Care Claim Payment/Advice (835) transaction, containing members' health care account payments, will have the same structure as the Health Care Claim Payment/Advice (835) transactions Highmark West Virginia currently produces. The health care account Health Care Claim Payment/Advice (835) transactions (ST to SE Segments) will be included in the Trading Partner's transmission file (ISA to IEA Segments) currently produced for Highmark West Virginia. Trading Partners will be able to distinguish the health care account Health Care Claim Payment/Advice (835) by the following features:

- Loop 1000A, N102 – The Payer Name will be 'Highmark 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: Health Care Claim Payment/Advice (835) Segments Documenting Payment from Highmark West Virginia and Payment from the Member's Account

The example below illustrates the 'COB reporting model' and Health Care Claim Payment/Advice (835) segments

documenting claim payment from Highmark 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 Health Care Claim Payment/Advice (835) transaction. The entire patient deductible of $130 is being reimbursed by the member's health care account. The $70 difference ($20 Contractual Obligation plus $50 paid by Highmark 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)	**Health Care Account Payment (Secondary**
N1^PR^HIGHMARK WEST VIRGINIA~ CLP^ABC123^1^200^50^130^12^0123456789~ NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ SVC^HC>99245^200^50~ DTM^150^20090301~ DTM^151^20090304~ CAS^CO^45^20~ CAS^PR^1^130~	N1^PR^HIGHMARK WEST VIRGINIA HEALTH CARE ACCOUNT~ CLP^ABC123^2^200^130^^12^0123456789~ NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ SVC^HC>99245^200^130~ DTM^150^20090301~ DTM^151^20090304~ CAS^OA^23^70~

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

Highmark West Virginia implemented real-time capability for claim adjudication and claim estimation. A real-time Health Care Claim Payment/Advice (835) will be used as the response to a real-time claim adjudication or electronic claim[1] estimation request. The real-time Health Care Claim Payment/Advice (835) response will contain the finalized results from successful claim

adjudication or estimation requests. The real-time Health Care Claim Payment/Advice (835) response will be based on the ASC X12N Health Care Claim Payment/Advice (835) Transaction adopted under the HIPAA Administrative Simplification Electronic Transaction rule.

For information on connectivity and the related transactions for real- time claim adjudication and estimation, see Section 4.2 of the Communication/Connectivity Companion Guide.

- Real-Time Response for Claim Adjudication

  The real-time Health Care Claim Payment/Advice (835) response for real-time claim adjudication will not contain the actual payment/check information. Actual payment for real-time adjudicated claims will continue to be generated through weekly payment cycles and be subsequently reported in the respective batch payment cycles or payment Health Care Claim Payment/Advice (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 Health Care Claim Payment/Advice (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 Health Care Claim Payment/Advice (835). See Section 5.2.4 for information on provider payments from member health care accounts.

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

835 Data	835 Element	Comments
835 Handling Code	BPR01=H	Required element – Indicates Notification only". No actual

835 Data	835 Element	Comments
		payment is being made.
835 “Payment” Amount	BPR02= CLP04	Required elements - The Real-Time Health Care Claim Payment/Advice (835) "payment" amount (BPR02) will equal the claim "paid" amount (CLP04) since this will be a single claim Health Care Claim Payment/Advice (835).
Payment Method	BPR04= NON	Required element - Indicates "Non- Payment Data". This is an informational only Health Care Claim Payment/Advice (835) and no dollars are being moved
Check/EFT/ Trace Number	TRN02	Required element -A non-payment Trace Number will be created. This number has no real value in the Real-Time Health Care Claim Payment/Advice (835) Response environment.
Claim Data	Loops 2000, 2100 & 2110	The claims data will be reported as adjudicated with appropriate liabilities and provider ‘payment’ amount

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

  The real-time Health Care Claim Payment/Advice (835) response for a real-time claim estimation request will follow the guidelines defined in the ASC X12N Health Care Claim Payment/Advice (835) Guide, Section 2.2.7 for "Predetermination of Benefits".

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

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

835 Data	835 Element/Segment	Comments
835 Handling Code	BPR01=H	Required element – Indicates Notification only". No actual payment is being made.
Check Payment	BPR02=0	Required element – An estimation Amount 835 Check Payment Amount will equal 0.
Payment Amount	BPR04= NON	Required element - Indicates "Non- Payment Data". This is an informational only Health Care Claim Payment/Advice (835) and no dollars are being moved
Check/EFT/ Trace Number	TRN02	Required element -A non-payment Trace Number will be created. This number has no real value in the Real-Time Health Care Claim Payment/Advice (835) Response environment.
Claim Status	CLP02	Required element - Code 25: Predetermination Pricing Only - No Payment.
Claim Paid	CLP04	Required element - The Claim Paid amount will equal 0
Service Paid	SVC03	Required element - The Service Paid amount will equal 0.
Claim/Service Adjustment	CAS	CAS Segment will report all member and provider contractual liabilities. The estimated provider paid amount will be assigned Group and Reason Code OA101. This CAS Segment adjustment will

835 Data	835 Element/Segment	Comments
		bring the claim paid amount and service paid amount to 0. CAS*OA*101*$$$$ CAS is reported at the applicable Line or Claim level.

- Real-Time General Requirements and Best Practices

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

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

    - Best Practice: Trading Partners are strongly recommended to have a user-friendly messaging screen that can be displayed, printed, and handed to a member to show adjudication or estimation results from the real-time Health Care Claim Payment/Advice (835). Highmark 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 Health Care Claim Payment/Advice (835).

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

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

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

- Best Practice: If services are rendered based on an estimate, the provider may post dollars received from the member based on the reported member liability from the proposed services, but not post the contractual obligation amounts until the services are rendered, the claim is submitted, adjudicated and finalized. The provider's systems should have the capability to record member liability collected, if the feature does not already exist with the system.

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

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

5.2.5 005010X212 Health Care Claim Status Request and Response (276/277)

This information will be provided at a future date.

5.2.6 005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271)

This information will be provided at a future date.

5.2.7 005010X217 Health Care Services Review-Request for Review and Response (278)

This information will be provided at a future date.

5.2.8 005010X231 Implementation Acknowledgment for Health Care Insurance (999)

Highmark West Virginia and HHIC return an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode. In real-time mode, a rejected Implementation Acknowledgment for Health Care Insurance (999) is returned only when the applicable real-time response transaction cannot be returned due to rejections at this level. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

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

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

Rejection codes are contained in the ASC X12C 005010X231 Implementation Acknowledgement for Health Care Insurance (999) national Implementation Guide. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA - IEA) and Functional Group (GS - GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be

"005010", indicating a generic 5010 Implementation Acknowledgment for Health Care Insurance (999) transaction. Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. This difference is because the Implementation Acknowledgment for Health Care Insurance (999) is generic to the 5010 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 Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter. In the following example the IK404 value 'TRADING PARTNER PROFILE' indicates that one or more incorrect values were submitted. In order to process your submission, these values must be corrected and the transaction resubmitted.

```
ISA^00^          ^00^          ^33^54828          ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03
IK3^GS^114^^8
IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
IEA^1^035738627
```