

Chapter 5

Claims Submission

Unit 2: Claims Submission and Billing Information

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5.2 Verifying Eligibility

Overview Highmark Blue Shield processes over 326,000 medical claims per day. During 2006, it processed over 81 million medical claims. The Company could not have accomplished this without the cooperation of providers, office and medical assistants who prepare and submit claims to Highmark Blue Shield.

Verifying Eligibility There are several ways to verify eligibility of Highmark Blue Shield members: member identification cards, NaviNet, the EDI 270/271 transaction, InfoFax, and OASIS.

To verify eligibility for BlueCard members, please use NaviNet or call 1-800-676-BLUE. For additional information about BlueCard, refer to the BlueCard Information Center located on the Provider Resource Center of NaviNet or the Highmark Web site.

Member Identification Cards Highmark Blue Shield issues members a variety of identification cards, depending upon the type of program and the location of the Blue Plan through which members are enrolled. Practices with the fewest claim submission errors generally require the member to show the current ID card with each visit and verify eligibility on every visit/service. This is why it is important that you check the member's identification card prior to each visit or service you provide. Generally, the identification card includes the following information:

- Subscriber's name; dependent's name;
- Identification number – alpha numeric* characters used to identify the member (the member's Unique Member Identifier [UMI]);
- Group number – a series of alphabetical and numeric characters assigned to employment groups, professional associations and direct payment programs;
- Plan code – three digits that identify the Blue Plan through which the member is enrolled;
- Type of agreement – a brief description of the type of agreements and coverage of the member. Not all identification cards have this information;
- BlueCard – all BlueCard members can be identified by a three-digit alphabetical prefix preceding the member identification number on their identification card. Always report the three-digit alpha prefix from any ID card.

*Alphabetical prefixes are used in conjunction with the identification number to identify the member's coverage. Members may have more than one identification card, depending on the type(s) of coverage in which members are enrolled. Please verify the correct alpha prefix is billed for the type of service reported.

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5.2 Verifying Eligibility, Continued

Member Identification Cards, continued

Examples of some identification cards are included in Chapter 3, Unit 2. Since the Blue Plans periodically update the format of the identification cards, the information provided on the sample identification cards may change without prior notice.

NaviNet

NaviNet is our primary resource for providers to obtain their data on Highmark Blue Shield patients. This Internet-based service enables you to access enrollment and benefits information, claims status, program allowances, accounts receivable management as well as many other sources that will help you find information about your Highmark Blue Shield patients. This time-saving service is provided free of charge to providers who have a large volume of Highmark Blue Shield members and will utilize the service.

InfoFax

InfoFax is a free service that allows you access to enrollment and limited benefits information and claims status through the use of your touch-tone telephone. The information is sent to your fax machine.

InfoFax is similar to OASIS in that you enter the patient's information into the system through your touch-tone telephone. Instead of the information being read back to you, the response is faxed to you in minutes.

Please refer to Chapter 1, Unit 2, "Highmark's Informational Resources," for more information about InfoFax.

OASIS

OASIS (Office Assistance Information System) is Highmark Blue Shield's fully-automated telephone response service. Providers may call OASIS on a touch-tone telephone to obtain enrollment and claim status information.

OASIS is easy to use and provides clear and concise information about Highmark Blue Shield's Medical-Surgical, Medicare Supplemental and Major Medical programs. The service is available 7 a.m. to 11 p.m., Monday through Friday, and 7 a.m. to 5 p.m., Saturday and Sunday. It allows for unlimited inquiries on multiple patients per telephone call. Two specific areas of information are available through OASIS: *Enrollment inquiry and status of claim inquiry*.

To access OASIS, call 1-800-462-7474, or in the Harrisburg area, 1-717-302-5125 on your touch-tone telephone.

Please refer to Chapter 1, Unit 2 "Highmark's Informational Resources" for more information about OASIS.

5.2 General Guidelines for Submitting Claims

Overview

In today's business world, there are no requirements to submit claims on paper. Electronic transactions and online communications are integral to health care. In fact, Highmark Blue Shield's claim system places higher priority on processing and payment of claims filed electronically. If you are not already billing electronically, please refer to Chapter 5, Unit 1, "Benefits of Electronic Communication," for information on how to take advantage of the electronic solutions available to you.

For Paper Claims

If you must submit paper claims, always print or type all information on the claim form. Clear, concise reporting on the form helps us to interpret the information correctly.

Complete the claim form in its entirety. Our claims examiners code each claim individually. If you submit several claim forms for the same member, but fill in only essential details on one form, Highmark Blue Shield will reject the claim forms.

In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.

Mail the claim forms to the appropriate PO Box address. A complete listing of addresses can be found in Chapter 1, Unit 1 "Quick Reference Directory."

Timely Filing

Timely filing is a Highmark Blue Shield requirement whereby a claim must be filed within a certain time period after the last date of service relating to such claim or the payment/denial of the primary payor, or it will be denied by Highmark. Per the timely filing policy, any claim not received within **365 days** of the last date of service will be denied for untimeliness. This policy applies to all Highmark Blue Shield providers. Claims submitted with an attached EOB are to be received within the 365 days of the primary payor's finalized or payment date, as depicted on the claim attachment.

Avoid Form 1099-Misc Errors

How you complete your claim form affects how your income is reported to the Internal Revenue Service (IRS). Highmark Blue Shield must notify the IRS of payments of \$600 or more it makes to a provider or practice within a calendar year. If you received payments of \$600 or more from Highmark Blue Shield in any calendar year, Highmark Blue Shield will send you a miscellaneous income statement (form 1099-Misc) at the end of January of the following year.

So that Highmark Blue Shield reports your correct income to the IRS, please follow these guidelines:

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5.2 General Guidelines for Submitting Claims, Continued

Avoid Form 1099-Misc Errors, continued

If the income is to be reported under the practice's name (group name) and tax identification number (TIN), please enter the Highmark Blue Shield group provider number or NPI number in the billing provider box on the claim form. Highmark Blue Shield will then issue all checks payable to the group's name. The 1099-Misc form will also be issued under the group's name.

If the income is to be reported under an individual's name and Social Security Number, (in the case of a sole proprietor), please enter the Highmark Blue Shield individual provider number or NPI number in the billing provider box on the claim form. Highmark Blue Shield will issue all checks payable to the individual provider's name. The 1099-Misc form will also be issued under the individual's name.

Note: Highmark Blue Shield will not make changes to form 1099 if the claims (paper or electronic) were submitted with the performing provider incorrectly listed as the billing provider.

For Central, Eastern, and Western Region Providers:

If you have any questions about form 1099-Misc issues, please call 1-866-425-8275. You can also e-mail 1099inquiry@highmark.com.

For Northeastern Region Providers:

For providers located within the 13 counties of Northeastern Pennsylvania, (Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming), please call 1-800-451-4447.

5.2 Concurrent Major Medical Processing

Overview

Concurrent Major Medical processing is a feature included with our ClassicBlue Traditional product. ClassicBlue Traditional offers basic medical-surgical, hospital and major medical coverage as one benefit package. For processing and payment purposes, the major medical benefits are incorporated into the traditional benefits.

This process simplifies the billing process for providers, who can report **all** professional services on one claim form and send it either electronically or on paper to Highmark Blue Shield. The services will process for basic coverage first and then automatically process for major medical coverage. One Explanation of Benefits shows you the details of both the basic and major medical processing. Please refer to pages 56-57 for an example of a Concurrent Major Medical Explanation of Benefits.

You will receive the standard Explanation of Benefits for members who do not have concurrent major medical processing.

5.2 OCR Scanning of Paper Claims

OCR Scanner Improves Paper Claims Processing Time

Highmark Blue Shield uses an OCR (Optical Character Recognition) scanner for direct entry of paper claims and encounters into its claims processing system, OSCAR (Optimum System for Claims Adjudication and Reporting). OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and “reads” the printed data then translates it into a format for direct entry into OSCAR. The scanner can “read” both computer-prepared and typewritten claim forms but **only if the data is within the borders of each box.**

Direct entry of claims by the OCR scanner is an advantage to you because it requires less human intervention in preparing and entering your claims. The scanner reads, numbers, and images your paper claims in one step. OCR scanning reduces claim entry time as well as entry errors. However, OCR claims do not receive the same priority processing as do electronically submitted claims.

For the most efficient processing, please use the CMS-1500 (08/05) red, claim form. The OCR scanner is programmed to read this form. To obtain a supply of the CMS-1500 (08/05) claim form, please contact your current forms distributor. If your forms distributor needs a negative or PDF of the claim form, they should e-mail or call:

- TFP Data Systems, e-mail: 1500form@tfpdata.com or 1-800-482-9367, extension 1770
OR
- Government Printing Office at 1-202-512-0455.

If you use computer billing software to complete the CMS-1500 (08/05) paper claim forms, please do not use your software for the previous CMS-1500 (12/90) version of the claim form. If this is used, it causes information to be aligned incorrectly and the OCR equipment cannot properly scan the form.

5.2 Tips for Submitting Paper Claims

Tips for Submitting Paper Claims

To ensure your claims are scanned as quickly as possible, processed accurately and paid without delay, please follow these guidelines when completing the claim form:

- Use computer-printed forms or type the data within the boundaries of the boxes provided. **DO NOT HAND WRITE.**
- The claim form can only accommodate six lines of service. The top area of the six service lines is shaded and is the location for reporting supplemental information. Supplemental information can only be entered with a corresponding, completed service line. It is not intended to allow the billing of 12 lines of service.
- Fill in the information requested. We must have complete information before we can process the claim. If details are missing, Highmark Blue Shield will reject the claim.
- If using a rubber stamp, do not stamp information in or over boxes one through 33 or in the upper right hand corner of the claim form. Any stamps used should be in black ink only.
- Regularly change your print ribbon to ensure print readability. Light print cannot be read by the scanner.
- Always provide Highmark Blue Shield with the original claim form. Do not send copies of claims – they cannot be scanned. If you use a two-part form, send the original claim (red fields - top form) rather than the copy (black and white - bottom form).
- Avoid using special characters such as dollar signs, hyphens, slashes or periods.
- Avoid extra labeling in boxes on claim form.
- Use X's for marking Yes or No blocks. Do not use other alphabetical indicators such as Y for Yes, N for No, F for Female or M for Male.
- Use black ink. **Do not use red ink.** The OCR image scanner cannot read red ink.
- Do not use correction fluid on the claims.
- Use flat envelopes for mailing claims. Do not fold claim forms. Folded or wrinkled claim forms cannot be effectively read by the scanner.
- The OCR scanner is designed to read computer prepared or typewritten claim forms. Claims with superbill attachments cannot process through the OCR scanner. Type data from the superbill directly onto the claim form. Do not attach superbills for the same services you have reported on the claim form.
- Leave the upper right-hand corner of the claim form blank for internal purposes. If you need to print information at the top of the form, use the open space in the center.

Continued on next page

5.2 Tips for Submitting Paper Claims, Continued

Tips for Submitting Paper Claims, continued

- Report all information about a service on one line. If the service dates, diagnosis code, charge, etc., are reported on separate lines, the scanner “creates” an extra line. This may cause the claim to be returned to you for correction and re-submission.
- Printing Specifications:
 - Use 10-pitch PICA type.
 - Submit all claims on 20 pound paper.
- Use the procedure code that most closely describes the service. Written descriptions are only necessary if using NOC codes or when no procedure code is available. Unnecessary descriptions are problematic for OCR scanned claims.
- Not Otherwise Classified (NOC) Codes – When reporting NOC procedure codes, provide a written description of the item or service above the code in the shaded area of the service line on the claim form. When more than one NOC is submitted, provide an individual description and charge for each item.
- **Do not** fill in blank fields or space with unnecessary data. For example, if hospitalization dates are not required, leave the field blank rather than entering 00/00/00 or XX/XX/XX.
- **Do not** use highlighters to emphasize information on the claim form or attachments. Highlighted information becomes blackened out when imaged and is not legible.
- In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.
- Verify patient and member information, via NaviNet before completing the claim form. Make sure that the member’s contract number is correctly reported on the claim form (including the alphabetical prefix) in the Insured’s I.D. Number box. Do not submit a photocopy of the member’s identification card.
- Submit a separate claim for each patient, even when they are members of the same family. When a patient has had multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include the date each service was provided in 6-digit format (MMDDYY).

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5.2 Tips for Submitting Paper Claims, Continued

Tips for Submitting Paper Claims, continued

- Include HCPCS codes to identify the service or services rendered. Other coding manuals may use the same code number to describe a different service.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment. Again, using the CMS-1500 (08/05) claim form will reduce the risk of error and expedite payment.
- Do not routinely send “Release of Information” forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Be certain the total charge equals the service line charges.
- Be sure to include your 10-digit NPI or Highmark provider number (The provider number includes two alphabetical or numeric characters plus one to nine numeric characters) in the Billing Provider Info & PH # box.
- Include coordination of benefits or Medicare information on the claim form when the patient qualifies.
- Claims and other documents (inquiries, referrals, etc.) should never be taped or glued in any way. Staples should be avoided unless absolutely necessary.
- Avoid the use of Post-it Notes on claims or inquiries. (Full sheets of paper are preferable.)
- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims. We will request this information if it is necessary to process the claim.
- Surgical procedures do not require operative notes unless:
 - An “individual consideration” (IC) or “unlisted procedure” code is reported.
 - The service performed is a new procedure.
 - The service performed is potentially cosmetic.
 - Multiple primary surgeons participated in a surgical procedure.
 - The terminology for the reported code indicates, “by report” (BR).
 - A pre-authorization letter advised you to submit specific reports.
 - The service involves unusual circumstances. Remember to also report modifier 22. If this modifier is not reported, the special circumstances will not be considered.
- When reporting circumcision for a baby boy, report the service on the baby’s claim, not the mother’s.
- When reporting services involving a multiple birth, report the services under the babies’ names, not as Baby A, Baby B, etc.

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5.2 Tips for Submitting Paper Claims, Continued

Tips for Submitting Paper Claims, continued (continued)

- Anytime you have a question about how to complete a claim form, contact Highmark Blue Shield's Provider Service department.

Examples Of How To Submit Claims Correctly

Insured's ID number	
Correct	Incorrect
YYZ1094657692001	YYZ-109-465-7692001
	ID # YYZ1094657692001
Charges	
Correct	Incorrect
20 00	\$20.00
Dates	
Correct	Incorrect
Date of Birth (use 8-digit format): 12271949	12/27/49 12-27-1949
All Other Dates, e.g., Dates of Service (use 6-digit format): 122749	12/27/49 12-27-49
Insured's policy group number	
Correct	Incorrect
123456	GRP # 123456
NAS123	GRP # NAS123

5.2 Tips for Submitting Paper Claims, Continued

Clean Claim Definitions and Requirements

The Prompt Payment Provision of Pennsylvania's Act 68 of 1998, which became effective on January 1, 1999, stipulates that health insurers pay "clean claims" within 45 days of receipt. A "clean claim" is defined as a claim with no defect or impropriety and one that includes all the substantiating documentation required to process the claim in a timely manner. The core data required on a claim to make it clean are outlined in this section.

"Unclean" claims are those claims where an investigation takes place outside of the corporation to verify or find missing core data. An example of this is when a request is sent to the member for information regarding coordination of benefits. This may require obtaining a copy of an Explanation of Benefits (EOB) from the member's other carrier. Claims are also considered unclean if a request is made to the health care professional for medical records. Claim investigations can delay the processing of the claim. The 45-day requirement only begins once all of the information needed to process the claim is obtained.

Highmark Blue Shield consistently processes claims well within the 45-day requirement. In fact, clean claims submitted electronically receive priority processing and are finalized within 7 to 14 days. With this in mind, we encourage you to submit all claims electronically to take advantage of the faster processing. For instructions on how to begin to submit claims electronically, please call EDI Operations at 1-800-992-0246.

You must provide us with the following information in order for the claim to be eligible for consideration as a "clean claim." If changes are made to the required data elements, this information shall be provided to network providers at least 30 days before the effective date of the changes. Please refer to the following section for more detailed explanations of these fields.

5.2 CMS-1500 (08/05) Claim Form Completion Instructions

Overview

The National Uniform Claim Committee (NUCC) released a new version of the 1500 Health Insurance Claim Form. The CMS-1500 (08/05) claim form replaced the 12/90 version on October 1, 2006. The instructions for completing the claim form are below. "New" is indicated in the boxes that were not on the 12/90 version. Please refer to Page 26 in this section for an example of a completed CMS-1500 (08/05) claim form.

Instructions for Completing the CMS-1500 (08/05) Form

The data, e.g., diagnosis codes, charges, NPIs, etc., used in the sample claim form is for the purpose of illustration only. Note: Please refer to pp. 29-46 for additional information about specific claim reporting situations.

Box #	Item Description	Instructions
TOP	Carrier Name Block	Report name and address in the center of the open space. Do not report above box 1a, as this is where Highmark prints the claim number.
1	Program Blocks	For Highmark products, you may place an X in the "Other" box.
1a	Insured's ID Number	Enter insured's identification number exactly as shown on the insured's identification card. Be sure to include any alpha prefixes.
2	Patient's Name	Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
3	Patient's Birth Date	Enter the patient's 8-digit birth date (MMDDCCYY). Enter an X in the correct box to indicate sex of the patient. Only one box can be marked. If gender is unknown, leave blank.
4	Insured's Name	Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Cpt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	Patient's Address	Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and telephone number.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to insured. Only one box can be marked.
7	Insured's Address	Enter the insured's address and telephone number. If box 4 is completed, then this box should also be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and telephone number.
8	Patient Status	Highmark does not need this information to adjudicate the claim.
9	Other Insured's Name	If box 11d is marked, complete boxes 9 and 9a-d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
9b	Other Insured's Date of Birth	Highmark does not need this information to adjudicate the claim.
9c	Employer's Name or School Name	Highmark does not need this information to adjudicate the claim.
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name.
10a - 10c	Is Patient's Condition Related to:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in box 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code must be shown if "YES" is marked in box 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
10d	Reserved for Local Use	Highmark requires the sub-set of Condition Codes approved by the NUCC in this field, when applicable. The Condition Codes approved for use on the 1500 Claim Form are available at http://www.nucc.org under Code Sets.
11	Insured's Policy Group or FECA Number	Enter the insured's policy or group number as it appears on the insured's health care identification card. If box 4 is completed, then this box should also be completed.
11a	Insured's Date of Birth	Enter the 8-digit date of birth (MMDDCCYY) of the insured and an X to indicate the sex of the insured. Only one box can be marked. If gender is unknown, leave blank.
11b	Employer's Name or School Name	Enter the name of the insured's employer or school.
11c	Insurance Plan Name or Program Name	Enter the insurance plan or program name of the insured.
11d	Is There Another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES," complete boxes 9 and 9a-d. Only one box can be marked.
12	Patient's or Authorized Person's Signature	Highmark does not need this information to adjudicate the claim. You may report "Signature on File," "SOF," or a legal signature in this block. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes and (2) enter the date signed in 6-digit format (MMDDYY). If there is no signature on file, leave blank or enter "No Signature on File."
13	Insured's or Authorized Person's Signature	Highmark does not need this information to adjudicate the claim. You may report "Signature on File," "SOF," or a legal signature in this box. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes and (2) enter the date signed in 6-digit format (MMDDYY). If there is no signature on file, leave blank or enter "No Signature on File."

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
14	Date of Current: Illness, Injury, Pregnancy	Enter the 6-digit (MMDDYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Be sure to complete this box when services were performed as a result of accident or injury.
15	If Patient Has Had Same or Similar Illness	Enter the first date the patient had the same or a similar illness. Enter the date in the 6-digit format (MMDDYY). Previous pregnancies are not a similar illness. Leave blank if unknown.
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, an 6-digit (MMDDYY) date must be shown for the "from-to" dates that the patient is unable to work. An entry in this box may indicate employment-related insurance coverage.
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim.
17a	Other ID #	<p>The Other ID number of the referring provider, ordering provider, or other source is reported in 17a in the shaded area. The two-digit qualifier indicating what the non-NPI number represents is reported in the qualifier field to the immediate right of box 17a. The NUCC defines many qualifiers, which also are used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following:</p> <p>1B Highmark Blue Shield Provider Number ZZ Provider Taxonomy</p> <p>Note: If you report an NPI number in box 17b, after May 23, 2007, you must report the taxonomy in this box. Prior to May 23, 2007, report the Highmark Blue Shield provider number in box 17a.</p>

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
17b	NPI	Enter the NPI number of the referring provider, ordering provider, or other source in box 17b. When reporting an NPI, you must report the taxonomy (not the Highmark Blue Shield Provider Number) in box 17a.
18	Hospitalization Dates Related to Current Services	Enter the inpatient 6-digit (MMDDYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization (inpatient services only).
19	Reserved for Local Use	Highmark does not need this information to adjudicate the claim.
20	Outside Lab	Highmark does not need this information to adjudicate the claim.
21	Diagnosis or Nature of Illness or Injury	<p>Enter the patient's diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Relate lines 1,2,3,4 to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this box.</p> <p>When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit to the right of the period. Please see page 27 for instructions regarding claims for FEP members and page 33 for reporting tips.</p>
22	Medicaid Resubmission Code/Original Reference Number	The left portion of this box is for Medicaid resubmissions only. The right portion, "Original Ref. No.," should be used to report the original Highmark claim number when this is a resubmitted claim.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

**Instructions for
Completing the
CMS-1500
Form, continued**

Box #	Item Description	Instructions								
23	Prior Authorization Number	For ambulance services, use this block to report the ZIP code of the Point of Origin. Ambulance providers who submit paper claims for non-emergent ambulance transports must attach a PMNC (Physician’s Medical Necessity Certification) form to the claim.								
24		<p>Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.</p> <p>The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.</p> <p>The following are types of supplemental information, and their qualifier, that can be entered in the shaded lines of box 24:</p> <table><tr><th>Qualifier</th><th>Type of Information</th></tr><tr><td>7 Anesthesia information</td><td>Anesthesia duration in hours and/or minutes with start and end times</td></tr><tr><td>ZZ Narrative description of unspecified code</td><td>Narrative description of unspecified code</td></tr><tr><td>N4 National Drug Codes (NDC)</td><td>National Drug Codes (NDC) for drugs</td></tr></table> <p>To enter supplemental information, begin at box 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.</p>	Qualifier	Type of Information	7 Anesthesia information	Anesthesia duration in hours and/or minutes with start and end times	ZZ Narrative description of unspecified code	Narrative description of unspecified code	N4 National Drug Codes (NDC)	National Drug Codes (NDC) for drugs
Qualifier	Type of Information									
7 Anesthesia information	Anesthesia duration in hours and/or minutes with start and end times									
ZZ Narrative description of unspecified code	Narrative description of unspecified code									
N4 National Drug Codes (NDC)	National Drug Codes (NDC) for drugs									

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

Instructions for Completing the CMS- 1500 Form, continued

Box #	Item Description	Instructions
24A	Dates of Service	Enter date(s) of service, from and to, in 6-digit format (MMDDYY). If one date of service only, enter that date under "From." Leave "To" blank. If grouping services, you may range date if the place of service, procedure code, charges, and individual provider for each line is identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in box 24G. An exception to this is prolonged detention care. Do not range date these services even when performed on consecutive days.
24B	Place of Service	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf
24C	EMG	Highmark does not need this information to adjudicate the claim.
24D	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of one procedure code and up to four, two-digit modifiers. The specific procedure code(s) must be shown without a narrative description. Please see pp. 31-35 for additional reporting tips.
24E	Diagnosis Pointer	Enter the diagnosis code reference number (pointer) as shown in box 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. If multiple numbers are used, do not use hyphens between the diagnosis pointers, e.g., 1-4 or 1, 3-5. (ICD-9-CM diagnosis codes must be entered in box 21 only. Do not enter them in box 24E.)

5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions				
24F	Charges	Enter the charge for each listed service. Enter the number right-justified in the dollar area of the box. Do not use commas or dollar signs when reporting the dollar amount. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.				
24G	Days or Units	<p>Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. When required by payers to provide the NDC units in addition to the HCPCS units, enter the applicable NDC units' qualifier and related units in the shaded line following the NDC qualifier and code.</p> <p>The following qualifiers are to be used when reporting NDC:</p> <table><tr><td>F2 International Unit</td><td>ML Milliliter</td></tr><tr><td>GR Gram</td><td>UN Unit</td></tr></table>	F2 International Unit	ML Milliliter	GR Gram	UN Unit
F2 International Unit	ML Milliliter					
GR Gram	UN Unit					
24H	EPSDT Family Plan	Highmark does not need this information to adjudicate the claim.				
24I	ID Qual.	<p>In the shaded area, enter the two-digit qualifier identifying the non-NPI number you report in box 24J. The Other ID# of the rendering provider is reported in box 24J in the shaded area. The NUCC defines many qualifiers, which are the same as those used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following qualifiers.</p> <p>1B Highmark Blue Shield Provider Number ZZ Provider Taxonomy</p> <p>The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the provider's Identification Number in boxes 24I and 24J only when different from data recorded in boxes 33a and 33b. In other words, when you report a billing provider (e.g., assignment account) in box 33, you must report the rendering/performing provider information in boxes 24I and 24J.</p>				

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
24J	Rendering Provider ID #	The individual rendering the service is reported in box 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the provider's Identification Number in boxes 24I and 24J only when different from data recorded in boxes 33a and 33b. In other words, when you report a billing provider (e.g., assignment account) in box 33, you must report the rendering/performing provider information in boxes 24I and 24J.
25	Federal Tax ID Number	Enter the federal tax ID (employer identification number) or Social Security Number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. This must be the tax ID which correlates to the billing provider reported in box 33.
26	Patient's Account Number	Optional. Highmark cannot provide this back to you on an Explanation of Benefits for paper claims. However, Highmark can reference this number when contacting your office for additional information.
27	Accept Assignment?	Enter an X in the correct box. Only one box can be marked. Note: this box is required for government claims only.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

**Instructions for
Completing the
CMS-1500
Form, continued**

Box #	Item Description	Instructions
28	Total Charge	Enter total charges for the services (i.e., total of all charges in column 24F). Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Balance Due	Enter total amount due. Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
31	Signature of Physician or Supplier including Degrees or Credentials	This box must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider's personal supervision. The name of the individual performing the service on the claim must be entered. The name may be computer printed or typed. Simply reporting the name of the group is insufficient.

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

**Instructions for
Completing the
CMS-1500
Form, continued**

Box #	Item Description	Instructions
32	Service Facility Location Information	<p>Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Enter the name and address information in the following format:</p> <p>1st Line – Name 2nd Line – Address 3rd Line - City, State and ZIP Code</p> <p>NOTE: Using the 9-digit ZIP + 4 code will result in faster and more accurate processing when the provider does not obtain an NPI for each Highmark provider ID number.</p> <p>Highmark requires the Service Facility Location when the service was performed at a secondary location and the provider's primary location was reported in box 33. Highmark always requires the Service Facility Location when the Place of Service reported in box 24B is one of the following:</p> <p>21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room – Hospital 31 - Skilled Nursing Facility 32 - Nursing Facility 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility</p>
32a (new)	NPI	Enter the NPI number of the service facility location

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
32b (new)		<p>Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines many qualifiers which are used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following qualifiers:</p> <p>1B Highmark Blue Shield Provider Number ZZ Provider Taxonomy</p> <p>NOTE: If you do not report an NPI number in box 32a, then report the Highmark Blue Shield Provider Number in this box, preceded by qualifier "1B." If you report an NPI number in box 32a, after May 23, 2007, you must report the taxonomy preceded by the two-digit qualifier ZZ in this box.</p>
33	Billing Provider Info & Ph #	<p>Box 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter the provider's or supplier's billing name, address, ZIP code, and telephone number. The telephone number is to be entered in the area to the right of the box title. Enter the name and address information in the following format:</p> <p>1st Line - Name 2nd Line - Address 3rd Line - City, State and ZIP Code</p>
33a (new)	NPI	Enter the NPI number of the billing provider reported in box 33.

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
33b (new)	Other	<p>Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines many qualifiers which are used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following:</p> <p>1B Highmark Blue Shield Provider Number ZZ Provider Taxonomy</p> <p>NOTE: If you do not report an NPI Number in 33a, then report the Highmark provider number in this box preceded by qualifier "1B." If you report an NPI number in box 33a, after May 23, 2007, you must report the taxonomy preceded by the two-digit qualifier ZZ in this box.</p>

Additional Edit Checks For Paper Billers

Effective April 11, 2008 Highmark will no longer attempt to correct Or retrieve missing information for the situations listed below. Instead, these situations will result in a rejection of the claim, and you will be required to resubmit a new claim with the corrected data.

[Tip Sheet](#)

When a claim rejects, it is important for your billing staff and/or vendor to understand exactly what was wrong and what is needed to correct it.

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Additional Edit Checks For Paper Billers If you submit paper claims, you may encounter the following denial codes and descriptions on your explanation of benefits notices.

Rejection Code	Rejection Code Description
B5606	In order to process the claim, additional information is required. Please resubmit the claim with a prescription for this service. Electronically enabled providers should resubmit electronically.
P5039	In order to process this claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered. Electronically enabled providers should resubmit electronically.
P5040	The patient's coverage does not provide for this service in the place of treatment reported. Therefore, no payment can be made.
P5010	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5011	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5012	The patient's sex is invalid for the reported procedure. Please resubmit the claim with verification of the patient's sex and/or a corrected procedure code or a complete description of service. Electronically enabled providers should resubmit electronically.

Printing Standards Use 10 pitch PICA. All paper claim submissions should be printed on the original CMS-1500 (08/05) claim form. Do not use photocopied forms or forms printed in black ink on a laser printer.

5.2 Example CMS-1500 (08/05) Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Highmark Blue Shield

P.O. Box 890173

Camp Hill, PA 17089-0173

[illegible]

5.2 Claim Inquiries

Choices

There are several choices available to check the status of a claim.

Offices may use:

- NaviNet
 - 276/277 Health Care Claim Status Request and Response Transaction (HIPAA mandated version)
 - Telephone
 - InfoFax
 - OASIS
-

NaviNet

NaviNet uses the Internet to link physician offices with Highmark computer systems.

Claim-related functions available on NaviNet include:

- Claims status inquiries
- Claim investigations
- Codes and allowances inquiries

NaviNet is the required method over telephone inquiries to check routine eligibility, benefits, and/or claims status for NaviNet enabled offices. Providers who are NaviNet enabled may also use the 276/277 Health Care Claim Status Request and Response or InfoFax, but not the telephone.

NaviNet is a service provided free of charge to providers who have a compatible computer system in their office and who will utilize the service. With NaviNet, providers can avoid the hassle of telephone inquiries for routine claims status or enrollment/benefit verification. To learn more about NaviNet or to become a NaviNet enabled office, please call the Provider Service Center at

Western Region: 1-800-547-3627, option 2.

Central Region: 1-800-345-3805, option 3.

[What Region Am I?](#)

Hours are from 9:00 a.m. to 4:30 p.m., Monday through Friday.

276/277 Health Care Claim Status Request and Response Transaction

Information about the Health Care Claim Status Request and Response (267/277) can be found in the Provider EDI Reference Guide or by contacting Highmark EDI Operations at 1-800-992-0246, option 2.

Continued on next page

5.2 Claim Inquiries, Continued

Telephone

Only those providers who do not have Highmark-hosted NaviNet, or who have non-routine inquiries that require analysis and/or research may contact the Provider Service Center at the following numbers:

- Western Region Medicare Advantage HMO claims: 1-866-517-8585
- Western Region: 1-800-547-3627, option 2
- Central Region: 1-866-731-8080
- Western & Central Region Medicare Advantage PPO Claims: 1-866-588-6967
- Eastern Region: 1-866-975-7290
- Northeastern Region (Traditional Participating Providers): 1-888-827-7117
- Northeastern Region BlueCare PPO (formerly AccessCare II): 1-866-262-5635

[What Region Am I?](#)

Before calling with an inquiry, please have the following information available so that the service representative may readily assist you:

- Patient name
- Member Identification Number
- Date of service
- Charge in question
- Your provider number or National Provider Identifier (NPI)
- Reason for your inquiry

InfoFax

InfoFax is an option for your office to receive information on enrollment, the status of claims, and limited benefits information and enrollment through your fax machine. After entering the patient's information into the system via your touch-tone phone, the information is faxed to you within minutes of your request.

Benefit information is also available for Medicare Supplemental contracts. You must use the patient's HIC (Medicare ID #) for information regarding this program.

InfoFax is available from:

- 7:00 a.m. to 9:00 p.m. (Weekdays)
- 7:00 a.m. to 2:00 p.m. (Saturday)

Continued on next page

5.2 Claim Inquiries, Continued

How To Gain Access To InfoFax

Simply call 1-800-891-1856 and enter your fax number including area code when prompted. An authorization form will be sent to your fax machine. Complete the authorization form and fax it to 1-800-985-6275. Once authorized to use InfoFax, a User Guide with complete instructions will be faxed to you. This process takes approximately 24-48 hours to complete.

If you would like any additional information about InfoFax, please contact the InfoFax Helpline at 1-800-985-2032.

OASIS (Office Assistance Information System)

OASIS is Highmark Blue Shield's automated voice-response system that gives you quick, direct inquiry access to enrollment and claim status information. OASIS provides concise and accurate information promptly for Highmark Blue Shield's medical-surgical and Medicare supplemental programs.

OASIS

The OASIS system allows you to access our data files through your touch-tone telephone. Because we have a toll-free number and extended hours, you can reduce administrative costs by calling OASIS. Any provider who has a valid Highmark Blue Shield provider number or National Provider Identifier (NPI) may call OASIS.

When you call OASIS, the system leads you through the information-gathering process with pre-recorded messages. Press the buttons on your telephone to access desired information.

To access OASIS, call:

Toll-free: 1-800-462-7474

In the Harrisburg area: 1-717-302-5125

Hours of operation:

Weekdays: 7:00 a.m. to 9:00 p.m.

Weekends: 7:00 a.m. to 5:00 p.m.

NOTE: OASIS can not provide status of a claim to a network provider if the claim processed through BlueCard and the member's coverage is through a plan outside of Pennsylvania.

When To Check Claim Status

Claim status questions should not be submitted until 30 days after the claim has been submitted.

5.2 Federal Employee Program (FEP) Processing

FEP Claim Tips

To ensure that your claims are accurately processed and paid without delay, please follow these guidelines in completing the claim form:

- When submitting claims for ambulance services, please include a completed trip report and detailed information concerning the medical necessity of the transport.
 - FEP Durable Medical Equipment (DME) claims: Claims submitted via paper or electronic method must be sent with a Certificate of Medical Necessity (CMN) the **first time** you submit a claim for the rental or purchase of a particular DME item. Paper claims and paper CMNs that are an attachment to an already electronically submitted claim should be sent to: FEP Claims, P.O. Box 898854, Camp Hill, PA 17089-8854. You can submit subsequent claims electronically for the same DME item, while the CMN is in effect – without submitting another copy of the CMN. To order the Highmark Blue Shield CMN form (No. CL328 G 7.03), call 717-302-5105.
 - Do not range date services.
 - Medications – When providing information about medication, be sure to include the name, the dosage and the individual charge for each drug. Be sure that this information is legible.
 - Use the appropriate address, P.O. Box 898854, when submitting claims.
 - When reporting inpatient services, also report the service facility name and address.
 - Submit FEP claims to the state where the services were rendered.
-

Special Notes On Diagnosis Coding For FEP Members

- Use special “V” *ICD-9-CM* diagnosis codes for FEP member claims. (The “V” codes are related to circumstances other than the specific diseases or injuries that are classified under categories 001.0 -999.9.) Following are specific “V” *ICD-9-CM* diagnosis codes that are valid for FEP claims: V40.0 – V40.9; V61.0 – V61.9; and V71.0 – V71.9. The codes must be used for claims for mental illness and should be reported to the highest level of specificity.
- Diagnosis codes 290.0 to 319 may also be used for claims for mental illness and must be reported to the highest level of specificity.
- When codes fall within 800.0 to 999.9, a condition must be reported for any accident or injury along with reporting the diagnosis to the highest level of specificity.

Please access the *ICD-9-CM* coding manual for the above-noted diagnosis codes.

5.2 Medicare Part B Supplemental Claims

Overview

For patients with Highmark Blue Shield Medicare Part B supplemental coverage, it is not necessary to submit a claim for payment after you submit one to Medicare Part B. The supplemental payment by Highmark Blue Shield should automatically follow the Medicare Part B payment. The Centers for Medicare & Medicaid Services consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBC automatically forwards Medicare claims to the secondary payer, eliminating the need for providers to separately bill the secondary payer.

The claims you submit to the Medicare carrier will cross over to the Blue Plan only after the Medicare carrier has processed them. The Medicare carrier automatically advises the Blue plan of Medicare's approved amount and payment for the billed services. Then, the Blue plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Medicare Benefits (EOMB) statement to the Blue plan after you receive the Medicare carrier's payment. Whether you submit electronic or paper claims, it is not necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

Please allow 30 days for the secondary claim to process. If you haven't received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status via NaviNet before resubmitting. To streamline the claim submission process to save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims. If there is not indication of a payment after checking the claim status, you can submit electronically using the PWK segment to fax the Explanation of Medicare Benefits (EOMB) statement or mail the EOMB with a completed CMS-1500 (08/05) claim form to:

Highmark Blue Shield
Medigap
P.O. Box 898845
Camp Hill, PA 17089-8845

or

Highmark Blue Shield
(for ClassicBlue, PPOBlue,
Medigap, and
DirectBlue)
P.O. Box 890052
Camp Hill, PA 17089-0052

Please be sure to submit the entire Explanation of Medicare Benefits statement. Do not highlight the Medicare payments in question. Either circle or place an asterisk (*) next to the information you want to bring to our attention. Provide the patient's Highmark Blue Shield identification number and their complete name and address.

5.2 Anesthesia Reporting Tips – Areas of Special Interest

Anesthesia Reporting Tips

For the most efficient processing of anesthesia services, submit claims electronically. If you bill electronically, please refer to the Highmark Provider EDI Reference Guide on the Provider Resource Center under Electronic Data Interchange (EDI) Services for billing instructions.

For more specific information about anesthesia services, please select Medical Policy from the Medical and Claim Payment Guidelines selection on the Provider Resource Center.

Coverage for services may vary for individual members, based on the terms of the benefit contract. Please check Highmark members' benefits via NaviNet or, if not-NaviNet enabled, call Provider Service. The listing of a procedure code and/or terminology in this section does not necessarily indicate coverage.

Anesthesia Procedure Codes

Use the national CPT (Current Procedural Terminology) anesthesia five-digit procedure codes (00100-01999) to report the administration of anesthesia along with national anesthesia modifier codes.

A description of service is required when a national anesthesia CPT code is reported. The best descriptor of the service is the surgical CPT code.

Payment Of Anesthesia Services

The following types of anesthesia qualify for payment as anesthesia services:

- Inhalation
- Regional
 - Spinal (low spinal, saddle block)
 - Epidural (caudal)
 - Nerve block (retrobulbar, brachial plexus block, etc.)
 - Field block
- Intravenous
- Rectal
- Moderate (conscious) sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (01991, 01992) (when the block or injection is performed by a different provider) is eligible for payment.

Local anesthesia (A9270) which is direct infiltration of the incision, wound, or lesion is not a covered service.

Payment for anesthesia services is evaluated according to the **base unit** value, plus **time units** reported, plus eligible **modifying units** when appropriate, multiplied by a **monetary conversion factor**.

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Anesthesia Base Units

Base unit values have been assigned to most anesthesia services (procedure codes 00100-01999) by the (ASA) American Society of Anesthesiologists Relative Value Guide and reflect the difficulty of the anesthesia service including the usual preoperative and postoperative care and evaluation.

The base value for anesthesia when multiple surgical procedures are performed is the base value for the procedure with the highest unit value. No payment is allowed for the base unit value of a second, third, etc., procedure.

When a surgical procedure is reported for which no base units have been assigned, a minimum of three base units will be assigned to the anesthesia service.

Anesthesia Time Units

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under customary postoperative supervision. You must document this time in the anesthesia record.

Report total anesthesia time as minutes. Time must be indicated on all anesthesia claims. Highmark will convert total minutes to time units. When calculating time units for the time actually spend administering anesthesia, each 15 minute segment or fraction thereof is considered one time unit. Report total anesthesia time as minutes in box 24G, "DAYS or UNITS," on the CMS-1500 (08/05) claim form.

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Medical Direction (supervision) Of Anesthesia

Highmark defines the medical direction or supervision of anesthesia as direction, management or instruction of anesthesia by one who is physically present or immediately available in the operating suite. A physician performing medical direction should not actually administer anesthesia.

Highmark limits reimbursement to the medical direction of no more than four anesthesia services being performed concurrently. When the physician is medically directing more than four procedures concurrently, he or she must submit documentation of the medical necessity for directing more than four procedures. Highmark will then review the claim on an individual consideration basis. A physician medically directing four or fewer anesthesia procedures can concurrently:

- address an emergency of short duration in the immediate area;
- administer an epidural or caudal anesthetic to ease labor pain;
- provide periodic, rather than continuous, monitoring of an obstetrical patient;
- receive patients entering the operating suite for the next surgery;
- check or discharge patients in the recovery room; or
- handle scheduling matters.

To identify who performed the anesthesia service, please report the appropriate anesthesia procedure code modifiers in conjunction with codes 00100-01999. Do not report the modifier's description on the claim form.

Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist (The AA modifier is one of several modifiers Highmark requires to identify who is performing an anesthesia service. Although this modifier's terminology states "performed personally by an anesthesiologist," any duly licensed and trained health care professional who is personally performing anesthesia services can report it. The AA modifier is not limited to physicians who specialize in anesthesiology.) Note: Do not report the AA modifier when the anesthesiologist is medically directing one or more anesthesiologists, regardless of the employment status of the anesthesiologists.
AD	Medical supervision by a physician: more than four concurrent procedures
GC	This service has been performed in part by a resident under the direction of a teaching physician
QK	Medical direction of two, three, or four concurrent anesthesia procedures

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Medical Direction (supervision) Of Anesthesia (continued)

Modifier	Description
QX	CRNA (Certified Registered Nurse Anesthetist) service with medical direction by a physician
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service without medical direction by a physician
47	<p>Anesthesia by surgeon: regional or general anesthesia provided by the operating surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.)</p> <ul style="list-style-type: none"> • Report modifier 47 in conjunction with the basic service, for example, the surgery code. • Do not use modifier 47 as a modifier for anesthesia codes 00100-01999. • Do not report modifier 47 for moderate sedation (see information about moderate sedation further in this unit.)

Medical Direction of a physician-in-training (e.g., intern or resident) – 100 percent total payment:

Report modifier GC. Payment will be made in the same manner as for the anesthesiologist's personal performance of the anesthesia service.

Medical Direction of an employed CRNA – 100 percent total payment:

When an anesthesiologist medically directs a CRNA, hired and paid by the anesthesiologist, **two lines on the claim form** are required when reporting the medical direction. Report modifiers QK and QX or QY and QX, as appropriate. Payment is made in the same manner as for the anesthesiologist's personal performance of the anesthesia service.

The employer (anesthesiologist) must be immediately available within the operating suite or within the immediate vicinity to assume primary care of the patient, if needed.

Report the name and Highmark provider ID number including the alpha prefix and/or NPI (National Provider Identifier) of the physician who is medically directing the service in box 24J of the CMS-1500 (08/05) claim form. Report the name of the physician who is medically directing the service in box 31 of the claim form. **Do not include the CRNA's name on the claim form.**

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Medical Direction (supervision) Of Anesthesia, continued

Medical Direction of Non-Employed CRNA – 50 percent total payment:

When an anesthesiologist medically directs a CRNA not employed by the anesthesiologist, e.g., hospital compensated, report modifier QK or QY, as appropriate. Payment of 50 percent of the fee allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist.

Medical Direction of Independently Practicing (non-employed) CRNA – 50 percent/50percent total payment:

When an anesthesiologist medically directs a CRNA who directly bills his/her services on a fee-for-service basis, i.e., independently practicing, the anesthesiologist should report modifiers QK or QY, as appropriate. The CRNA should report modifier QX. Payment of 50 percent of the fee that is allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist. The remaining 50 percent is paid to the CRNA who is directly billing his/her services on a fee-for-service basis.

Anesthesia Services Personally Performed by Physician – 100 percent total payment:

Report modifier AA when (1) the physician personally performs the entire service and (2) the physician is present in the operating room for the entire case and is actively participating in the administration of anesthesia, even if an anesthetist assists in the care of the patient.

Modifying Units

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required. Report modifying units (representative of age, total body hypothermia, controlled hypertension, and emergency) with the following HCPCS procedure codes. These procedure codes are not associated with number of units; therefore, please do not report additional units.

Highmark will pay these HCPCS codes at a flat fee. You must report procedure codes 99100, 99116, 99135 or 99140 on the same claim as the anesthesia service (00100-01999).

Code	Description
99100	Extreme age, under 1 year or 71 years of age or older
99116	Total body hypothermia
99135	Controlled hypertension
99140	Emergency conditions

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Modifying Units (continued)

Exception: You can report physical status with the applicable modifier. Report this modifier only in conjunction with the appropriate anesthesia procedure code (00100-01999).

The list of modifiers to report physical status include:

MODIFIER	DESCRIPTION	Modifying Units
P1	Physical status 1	0
P2	Physical status 2	0
P3	Physical status 3	1
P4	Physical status 4	2
P5	Physical status 5	3
P6	Physical status 6	0

CMS-1500 (08/05) Claim Example

Claim example for anesthesia services personally performed by physician:

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					E.	F.	G.	H.
From		To			PLACE OF							DIAGNOSIS		DAYS	EPS	
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER		POINTER	\$ CHARGES	OR	UNITS	Fam	
10	01	06				22		00300	AA	P2		765	00	47	Pla	

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Administration Of Anesthesia For Surgical And Nonsurgical Procedures, Same Provider

Anesthesia administered for covered services is eligible when rendered by a professional provider other than the operating surgeon, assistant surgeon, or attending professional provider.

When anesthesia is reported by the operating surgeon, assistant surgeon, or attending professional provider, it is not covered. A participating, preferred, or network provider can bill the member for the denied anesthesia service.

A benefit exception is anesthesia administered by the operating surgeon, assistant surgeon, or attending professional provider for covered oral surgical procedures. This anesthesia is eligible for payment in addition to the oral surgery when performed in any place of service other than inpatient.

Use modifier 47 (Anesthesia by surgeon) when general or regional anesthesia has been administered by the operating surgeon.

When moderate sedation, also referred to as conscious sedation, has been administered by the operating surgeon, report codes 99143-99145, as appropriate, and report with the AA modifier.

Modifier 59 is appropriate to use when a nerve block and surgery are reported by the same provider as treatment for two separate and distinct conditions, i.e., the nerve block is not performed as anesthesia for the surgery. In this instance, modifier 59 should be reported in conjunction with the nerve block procedure code.

Note:

When an associate or member of the same practice group (who is other than the operating surgeon, his assistant, or attending provider) administers anesthesia, payment can be made for covered anesthesia services.

Moderate (conscious) Sedation

Moderate sedation, also known as conscious sedation, induces an altered state of consciousness that minimizes pain and discomfort through the use of pain relievers and sedatives. Patients who receive moderate sedation usually are able to speak and respond throughout the procedure.

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Moderate (conscious) Sedation, continued

The administration of moderate sedation, also known as conscious sedation, for specified procedures, by the same provider (99143-99145) who is also performing the procedure, regardless of specialty, is not eligible for separate payment. In this instance, report procedure codes 99143-99145. Reimbursement for sedation is included in the global allowance for these procedures and, therefore, is not separately reimbursable. A network provider cannot bill the member for the moderate sedation. See Highmark [Medical Policy Bulletin A-17](#).

Moderate sedation performed with any other surgical procedure by the same provider is not covered. A participating, preferred or network provider can bill the member for the sedation in these cases.

Moderate sedation performed by other than the operating surgeon, assistant surgeon, or attending professional (99148-99150) for a covered surgical service is eligible for separate payment. When moderate sedation has been administered by the operating surgeon, report codes 99143-99145, as appropriate, with the AA modifier (anesthesia services performed personally by anesthesiologist), for example, 99143AA.

Because Highmark uses the anesthesia conversion factor to calculate its reimbursement for moderate sedation services (99143-99150), you must report anesthesia time incurred during “face-time” with the patient. If you do not, your claims may be delayed or may not be paid correctly. Please report total anesthesia time in minutes.

Other Modifiers

If anesthesia must be administered to a patient at two separate and distinct times during the same day, you must identify each anesthesia service performed within the separate session. Report modifier 78 or 79, as appropriate, on each service line of the claim form.

78 – Return to the operating room for a related procedure during the postoperative period

79 – Unrelated procedure or service by the same physician during the postoperative period

Consultation Services By An Anesthesiologis t

Highmark will pay for a consultation, preoperative work up, performed by an anesthesiologist prior to surgery, in accordance with the member’s benefits. A consultation is defined as a professional service furnished by a second physician at the written or verbal request of the attending physician. It includes a history, examination of the patient, evaluation of tests when applicable, and a written report files with the patient’s permanent record.

5.2 Diagnosis Coding Reporting Tips

Overview

Highmark Blue Shield requires you to report the highest level of specificity when reporting diagnosis codes from the *ICD-9-CM* (International Classification of Diseases, 9th Revision Clinical Modification) manual on its medical-surgical claim forms. The *ICD-9-CM* codes are used to assign numeric codes to disease, injuries, impairments, symptoms and causes of death. Since Highmark Blue Shield's claims processing system applies medical payment guidelines based on diagnosis codes, you must report the most appropriate three-, four- or five-digit diagnosis code on every claim. The diagnosis must be valid for the date of service reported.

Be As Accurate As Possible

Highmark Blue Shield will reject your claims for payment if you submit them without complete or accurate diagnosis codes.

NaviNet

NaviNet includes a diagnosis code inquiry that lets you look up diagnosis codes by code, description, start and end dates.

Please Note

For all lines of business:

1. Report diagnosis codes to the highest level of specificity available,
2. Substantiate all member diagnoses in the medical record.

For FreedomBlue PPO Members:

In addition to above, include all *ICD-9-CM* diagnosis codes that impact the patient's evaluation, care and treatment for the current problems.

5.2 Modifiers

Overview

A modifier is a two-character code – either numeric, alphabetical or alpha-numeric – that is placed after the usual procedure code. A modifier permits a provider to indicate whether a service or procedure has been altered by specific circumstances, but not changed its definition or code. Up to four modifiers can be reported for each service.

Essential Modifiers

Some modifiers that are essential to accurate claims processing, and that also must be reported on the claim form (when applicable) are:

Modifier	Definition
LT	Identifies procedures performed on the left side of the body.
RT	Identifies procedures performed on the right side of the body.
50	Identifies bilateral procedures. Unless otherwise identified by a specific code, bilateral procedures should be identified by adding a 50 modifier to the appropriate procedure code.

Our claims processing system is programmed to look for RT or LT modifiers on codes for services that may be performed bilaterally. When reporting a procedure that can be performed on either side of the body, report the appropriate RT or LT modifier. If neither the 50, RT or LT modifiers are reported, one of the services will be rejected as a duplicate.

Modifier	Definition
76	Repeat procedure by same physician. Use this modifier to report all procedures or portions of procedures that are repeated on the same date.

The 76 modifier should be applied to the subsequent or repeat procedure only. Failure to use this modifier when appropriate will result in a rejection, as the service will be read as a duplicate.

Modifier	Definition
22	Unusual Procedural Services: one that is of greater complexity than that usually required for the listed procedure – identify that service by adding a 22 modifier to the standard procedure code.

The 22 modifier distinguishes the procedure performed as an unusual service, including extenuating medical circumstances. When you report a procedure code with a 22 modifier, Highmark Blue Shield recommends that you submit your claim electronically through an 837 transaction and use the Paperwork (PWK) Segment to report the type and transmission of the attachment.

Continued on next page

5.2 Modifiers, Continued

Essential Modifiers, continued

Fax or mail supporting medical documentation to: (717) 302-3686, or mail to: PWK Additional Documentation, PO Box 890176, Camp Hill, PA 17089-0176. **Please do not submit with the claim.**

One of our Professional Consultants will review your claim and supporting documentation. He or she will determine whether or not additional reimbursement is warranted based on the clinical circumstances documented in the medical records, and if so, how much additional reimbursement is appropriate. Claims with a procedure code with a 22 modifier will be adjudicated and will receive one of the following message codes:

- J6056 – unusual procedural services were reported with no supporting documentation, therefore, no additional payment can be considered
- J6057 – unusual procedural services were reported and the supporting documentation was considered, but does not warrant an additional payment
- J6058 – unusual procedural services were reported and the supporting documentation was considered for the additional payment reflected under the allowance

Highmark Blue Shield will conduct a one-time review of the supporting medical documentation that was submitted with the claim. If, after reviewing the claim, Highmark Blue Shield determines that additional payment is not warranted, it will not review the supporting documentation a second time. In this case, Highmark Blue Shield will deny your claim and you will receive message code J6057.

If you submit a claim for a procedure with a 22 modifier and do not send the supporting medical records within 21 days, Highmark Blue Shield will process the claim without considering the 22 modifier and will notify you by including message code J6056 on your Explanation of Benefits form. Highmark Blue Shield will consider the procedure you reported at the standard allowance.

If you send supporting documentation to Highmark Blue Shield after your claim was processed, you should perform a claim investigation through NaviNet. Specific instructions as to where to submit supporting documentation will be included in the response to your claim investigation. If you are not NaviNet-enabled, contact Provider Service for instructions on how to submit your supporting documentation.

5.2 Reporting Bilateral Procedures

Bilateral Procedures

When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report. There are several ways to report bilateral procedures.

“Right” and “left” modifiers

If you report bilateral services on two lines of service, report an RT modifier on one line and an LT modifier on the other. The number of services on each line should be “1.”

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.
	From	MM	DD	YY	To	MM	DD	YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan
10	01	06					22				20610	RT	1234	35	00	1	
10	01	06					22				20610	LT	1234	35	00	1	

If you report bilateral services on one line of service, report RT and LT modifiers. The number of services should be “2.”

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.
	From	MM	DD	YY	To	MM	DD	YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan
10	01	06					22				20610	RT LT	1234	70	00	2	

“50” modifier – bilateral procedures that are performed at the same operative session. If you report a “50” modifier to indicate bilateral procedures, report only one line of service. The number of services should always be “2.”

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.
	From	MM	DD	YY	To	MM	DD	YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan
10	01	06					22				20610	50	1234	70	00	2	

Continued on next page

5.2 Reporting Bilateral Procedures, Continued

Bilateral Procedures (continued)

If you report multiple services performed on the same side of the body (for example, right shoulder, right hip), you may follow either of these examples:

24. A. DATE(S) OF SERVICE							B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER							
10	01	06					22		20610	RT			1234	70	00	2	

OR

24. A. DATE(S) OF SERVICE							B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER							
10	01	06					22		20610	RT			1234	35	00	1	
10	01	06					22		20610	RT	76		1234	35	00	1	

In this case, the 76 modifier must be reported on the second line that reports the same procedure code for correct payment to be made.

5.2 Range Dating

Overview

Do not range date services, **except** in the following situations:

1. DME monthly rentals
2. End stage renal disease (ESRD) related services, procedure codes 90918-90921
3. In-hospital medical visits may be range dated if the services are identical and the visits were provided on consecutive dates of service within the same calendar month. An **exception to this is prolonged detention care**. Do not range date these services even if rendered on consecutive days.
4. Weekly radiation therapy procedure codes 77427.
 - Five fractions of radiation therapy constitute a week of therapy, whether or not the fractions occur on consecutive days. Since the code represents a week (or five fractions) of therapy management, the number of services reported for each multiple of five fractions should be one unit. Radiation therapy services may be reported weekly or monthly. The number of services reported for a week of five fractions would be “one.”
 - A month of 20 fractions would be reported as four services.
 - Date of treatment weeks should not overlap. Rather, reported dates of services should span the range of dates involved.
 - Hyperfractions of radiation therapy occur when two smaller doses are given in one day of treatment. One week of hyperfractions would include 10 hyperfractions or five days. The number of services billed for that week should be “1.”
 - When providing radiation therapy services, the notation, “course of treatment ended” should only be used when the final treatment has been administered.

Note: Do not report future dates of service on the claim form. Only report services that have actually been rendered.

5.2 Documentation Requirements

Overview

Highmark Blue Shield requires that patient records document every service submitted for payment. This includes diagnostic tests, medical care, surgery and any other services eligible for payment by Highmark Blue Shield. Regulations issued by the Pennsylvania Board of Medical Education and Licensure support this policy.

You should not submit this documentation with your claims. If documentation is needed, Highmark Blue Shield will request it. Please retain your office records for audit purposes.

Hospital and office records must verify that a service: 1) was actually performed; 2) was performed at the level reported; and 3) was medically necessary. The services billed by the provider must be documented by personal notes and orders in the patient's records.

Criteria For Documentation Submission

Highmark Blue Shield will use this criteria to determine if the provider has met the appropriate documentation requirements:

- Hospital medical visits – The admission and discharge records, doctor's orders and progress notes should clearly reflect the type, level of care and medical necessity of treatment billed by the doctor. The records not only should reflect the doctor's personal involvement in treating the patient, but also should reflect and be co-signed by the interns and residents who write the progress notes and order sheets;
 - Surgical services – The operative report should indicate the name of the surgeon who performed the service. Minor surgical procedures not requiring an operative note must be documented in the progress notes. Also, the records should indicate the condition or diagnosis that documents the medical necessity for the surgery;
 - Consultation – A consultation includes a history and an examination of the patient by a consultant whose services were requested by the attending physician. There should be a written report signed by the consultant. Additionally, the medical necessity for the consultation must be documented;
 - Anesthesia – The anesthesia and/or operative report should indicate the name of the person who actually performed the anesthesia service. Anesthesia time units begin when the doctor begins to prepare the patient for induction and ends when the patient may be safely placed under postoperative supervision and the doctor is no longer in personal attendance. The records should reflect the actual time units reported;
-

Continued on next page

5.2 Documentation Requirements, Continued

**Criteria For
Documentation
Submission,
continued**

- Medical reports – Office records should contain the patient’s symptoms and/or complaints, diagnoses, tests performed, test results and treatment given or planned. In addition, the copies of hospital records should be clear and readable. In cases involving concurrent medical care, the consulting physician should submit these records with the request for review;
 - Emergency medical/accident – Claims for emergency medical and emergency accident services always should include a date of onset and a date of service. Emergency medical services should be reported with the appropriate evaluation and management code, the ET (emergency services) modifier and a diagnosis code that reflects an emergency medical service.
-

5.2 Defining Inpatient and Outpatient

Overview

When you submit claims to Highmark Blue Shield for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

Definitions

- **Outpatient** – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician's sole practice is located in a hospital or hospital owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved by Provider Data Analysis to be recognized as an office practice.
- **Inpatient** – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician's office, and is then returned to the hospital, the physician must report services according to the patient's status, in this case, inpatient. Therefore, you must report only "inpatient" as the place of service, rather than the place, such as "office" or "outpatient hospital", where the service actually was performed. For example, if a mobile ultrasound, MRI or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

For More Information

Please refer to Chapter 6, Unit 5, Outpatient Radiology and Other Diagnostic Services, for additional information on the Highmark Radiology Management Program's requirements for privileging of providers who perform diagnostic imaging and for prior authorization of selected outpatient advanced diagnostic imaging services, such as MRIs, MRAs, CT scans, and PET scans.

5.2 Claim Attachments for Electronic Claims

Electronic Claim Attachments

It isn't necessary or recommended that you submit claims requiring attachments via paper except in certain instances. (See information on when surgical procedures need operative notes under "Tips for Submitting Paper Claims" on page 8 and "Federal Employee Program (FEP) processing" on page 30.) These claims should be sent electronically utilizing the PWK, or paperwork attachment, specifications of the 837 electronic claim transaction. Two PWK option fields are built into the 837 transaction. To review the specifications and PWK process flow, please visit the Provider Resource Center, then Electronic Data Interchange (EDI), finally select, the Provider EDI Reference Guide under the Resources tab of the EDI Trading Partner website.

If you currently work with a trading partner (software vendor and/or clearinghouse) or have an information technology (IT) department within your practice they will be able to assist you with the technical aspects of the specifications. Simply tell your trading partner that you want to begin submitting attachment claims electronically.

Additional Information Requests

If Highmark requires additional documentation to process the claim, you will be contacted after Highmark has started to review it.

Reminder

Highmark Blue Shield's medical-surgical claims processing system places a higher priority on claims filed electronically.

Facility Identification Numbers

To help decrease processing time when reporting inpatient and outpatient services performed at facilities such as hospitals, skilled nursing facilities, nursing homes, etc., Highmark Blue Shield has implemented a facility coding system. You must report an eight-digit alphanumeric facility identification number and/or facility National Provider Identification (NPI) number in addition to the facility name and address in box 32 of the claim form. Claims submitted without the necessary information may result in payment delays.

Continued on next page

5.2 Claim Attachments for Electronic Claims, Continued

**Facility
Identification
Numbers**
(continued)

For the electronic claims biller, it is important to report the facility identification number without alphabetical characters. The facility identification number is required when you are reporting services that were rendered in an inpatient, outpatient or skilled nursing facility. Please visit NaviNet to find a listing of all licensed facilities under 'Network Facility Inquiry'. You may also refer to Chapter 7, Unit 1 for a listing of all CMS National Provider Identifier (NPI) data. The list will help you report the appropriate facility identification number. It is sorted alphabetically by facility name and includes the address and the eight-digit facility identification number.

5.2 Explanation of Benefits for Medical-Surgical Contracts

For Network Providers

An Explanation of Benefits (EOB) statement is sent to network providers and to members. Along with the claim payments, network providers receive an EOB listing all claims processed each week. This EOB lists each patient's claim separately. Each individual member on the provider's EOB will also receive an EOB listing the services processed. (See example of provider EOB later in this unit.)

NaviNet-enabled providers can view EOBs on NaviNet.

Non-Network Providers

Non-network providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-network provider for services performed.

Information on EOB

Both the network provider and member EOB contain the following key information:

- Patient's name
- Identification number
- Member's name
- Claim number
- Date of service
- Procedure code
- Doctor's charge
- Highmark Blue Shield's allowance
- Amount applied to deductible
- Amount applied to co-insurance
- Amount deducted for coordination of benefits

If A Provider Identifies An Overpayment

Highmark Blue Shield offers a streamlined process that simplifies how you notify claim overpayment information electronically. Below is how the process works.

If a provider identifies an overpayment

- All Highmark-hosted NaviNet-enabled professional providers must use the Claim Investigation function to notify Highmark Blue Shield of an overpayment. If you are not NaviNet-enabled and an overpayment was made, call Highmark Blue Shield's Provider Service to advise if you want the overpayment offset from a future check.

Continued on next page

5.2 Explanation of Benefits for Medical-Surgical Contracts, Continued

If a provider identifies an overpayment, (continued)

- If Highmark Blue Shield agrees that an overpayment exists, it will adjust the payment so that the next Explanation of Benefits (EOB) statement and Electronic Remittance Advice (835) transaction (if used) will include details of the changes in the payment. It will also reduce the total payment for that EOB/835 by the amount of the overpayment. The EOB/835 detail, on a line-item basis, is clear and easy to post in your accounts receivable software. If you take advantage of the Electronic Remittance Advice 835 transaction, your office can automatically post the refund.
- While less desirable, if you prefer to refund the amount of overpayment by sending a check, please do not use NaviNet Claim Investigations or call Highmark Blue Shield's Customer Service. Rather, send a check and a copy of the EOB with the overpaid claim circled to:

Cashier
P.O. Box 890150
Camp Hill, PA 17089

Highmark Identifies Overpayments

If Highmark Blue Shield identifies an overpayment:

- Highmark Blue Shield will notify your practice of all overpayments on a separate section of the EOB and Electronic Remittance Advice (835) transaction, if used. Highmark Blue Shield will no longer send notification of overpayment letters to you. The overpayment details in the new section of the EOB (future offset summary) and 835 reference an overpayment that will be withheld from a future check.
- The EOB/835 provides detail as to the reason for the refund request. It serves as notice that unless appealed or paid by check, the overpayment will be deducted from an EOB/835 approximately 60 days following the notification.
- If you agree with the refund request, you should take no action. Highmark Blue Shield will automatically deduct the overpayment from a future check. The deduction will be indicated on your EOB/835. If you do not want the overpayment withheld from a future check but prefer to write a check for the overpayment, send the check and a copy of the EOB with the overpaid claim circled to:

Cashier
P.O. Box 890150
Camp Hill, PA 17089

5.2 Explanation of Benefits for Medicare Part B Supplemental Contracts

Assigned Providers	An EOB statement is sent to assigned providers and to members. Assigned providers will receive an EOB showing all claims processed each week. This EOB lists each patient's claim separately. Each individual member on the provider's EOB also receives an EOB listing the services processed. (See Example of a Medicare Supplemental Provider EOB, on pp. 58-59.)
Non-assigned Providers	Non-assigned providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-assigned provider for services performed.
Information on EOB	Both the assigned provider and member EOB contain the following: <ul style="list-style-type: none"> ■ Patient's name ■ Medicare health insurance claim (HIC) number ■ Claim number ■ Date of service ■ Procedure code ■ Provider's charge ■ Medicare approved amount ■ Highmark Blue Shield's allowance ■ Amount applied to Medicare Part B deductible
Inquiries About EOBs	Members should direct their questions or comments to the phone number listed on their EOB. Network providers should use NaviNet to contact Highmark Blue Shield's Customer Service department if they have questions about coverage or disagree with the determination of a claim. For more information about inquiries please see Chapter 1, Unit 2, "Highmark's Informational Resources."
Please Note	The EOBs you receive may vary slightly in format from the examples on the following pages.

5.2 Example of Medical-Surgical EOB



Page 1 of x

SEPTEMBER 08, 2006

**EXPLANATION OF BENEFITS
CHECK IS ENCLOSED**

PROVIDER SUMMARY

[illegible]

Provider Number: 000000000

PAYMENT SUMMARY

PROVIDER CHECK NUMBER 000000000

TOTAL PROVIDER PAYMENTS	\$0,000.00
-------------------------------	------------

TOTAL INTEREST CALCULATED	\$0.00
---------------------------------	--------

TOTAL MEMBER PAYMENTS	\$0.00
-----------------------------	--------



Camp Hill, PA 17089

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=====|||====|||====|||====|||====|||====|||====|||====|||====|||=====
===== PROVIDER NAME
===== STREET
===== CITY ST ZIP CODE
=====
```

PF000000

"VISIT US AT OUR WEBSITE: www.highmark.com"



5.2 Example of Medical-Surgical EOB, continued

Page 8 of X
SEPTEMBER 08, 2006

Provider Number: 000 0000000
Provider Name: xxxxxxxxxxxxxxxxxxxxxxx

DATE(S) OF SVC	NUM OF SVC	REVENUE/ PROCEDURE CODE	PAY- MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON- CHARGEABLE AMOUNT	NON- CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (' = MEMBER)	MESSAGE CODES
----------------------	------------------	-------------------------------	----------------------	--------------------	------------------	------------------------------	---------------------	-------------------------------	---------------------	-----------------	-----------------------------------	------------------

CLAIM NUMBER:
0000000000

PATIENT: NAME
MEMBER: NAME

PATIENT ACCT #:
MEMBER ID: 000000000000

9/7/28/06	157012	150283	014	53.00	35.00	31.00		6.60	C1		26.40	J9040
9/7/28/06	150283	150283	014	51.00	31.00	31.00		6.20	C1		24.80	J9040
9/7/28/06	257140	257140	014	60.00	60.00	60.00		12.00	C1		48.00	J9040
9/7/21/06	150283	150283	014	51.00	31.00	31.00		6.20	C1		24.80	J9040
9/7/21/06	157035	157035	014	50.00	30.00	30.00		6.00	C1		24.00	J9040
9/7/21/06	257140	257140	014	60.00	60.00	60.00		12.00	C1		48.00	J9040
9/7/25/06	157012	150283	014	53.00	35.00	31.00		6.60	C1		26.40	J9040
9/7/25/06	150283	150283	014	51.00	31.00	31.00		6.20	C1		24.80	J9040
9/7/25/06	257140	257140	014	60.00	60.00	60.00		12.00	C1		48.00	J9040
CLAIM TOTALS											295.20	

CLAIM SPECIFIC MESSAGE(S):
We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

MESSAGE(S):
J9040 If you have any questions, call 1-866-731-8080 or the Western District Office 1-800-547-3627 or the Eastern District Office (215) 564-2131.
X5018 The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.
J6066 If you have any questions, call 1-866-588-6967.
S5002 Coverage was cancelled prior to the date of service. Therefore, no payment can be made.
J9043 If you have any questions, call 1-800-241-5704.
S0190 We are unable to identify this patient from the information submitted. Please verify the first and last name, alpha prefix, and number indicated on the identification card, along with the patient's sex and date of birth. If the patient is covered by us, please resubmit with corrected information.
VOID This service has been corrected. Amounts appearing on this line are not included in the totals line, as they were previously processed on the original claim. Please refer to the original Explanation of Benefits or Claim Notice for information on this line.
J0080 If you have questions, please call 1-866-731-8080.
J8060 Our payment was reduced due to a payment made by Medicare. The OTHER AMOUNT may not match Medicare's payment. Since you agreed to accept Medicare's allowance as full payment, our payment combined with Medicare's cannot exceed the Medicare allowance.

PAYMENT CODES:
014 = REASONABLE BENEFIT MAX/MAJ MED
023 = PREMIERBLUE SHIELD
026 = CONTRACTED ALLOWANCE
027 = PROGRAM ALLOWANCE


NON-CHARGEABLE AMOUNT CODES:
07 = Rejected Non-Billable Services
25 = Differential

MEMBER LIABILITY CODES:
A1 = Deductible
C1 = Coinsurance
D1 = Copay
H1 = Rejected Billable Non-Covered



PF011834

5.2 Example of Concurrent Major Medical EOB

 <p>HIGHMARK[®] BLUE SHIELD <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small></p>	<p>EXPLANATION OF BENEFITS</p> <p>CHECK IS ENCLOSED</p>	<p>Page 1 of x</p> <p>SEPTEMBER 29, 2006</p>
--	---	--

PROVIDER SUMMARY	
Provider:	FNAME LNAME, DC
Provider Number:	000000000


PAYMENT SUMMARY	
PROVIDER CHECK NUMBER	000000000
TOTAL PROVIDER PAYMENTS	\$000.00
TOTAL INTEREST CALCULATED	\$0.00
TOTAL MEMBER PAYMENTS	\$0.00

5.2 Example of Concurrent Major Medical EOB, continued

Provider Number: 000 0000000										Page 2 of x			
Provider Name: FNAME LNAME, DC										SEPTEMBER 29, 200			
DATE(S) OF SVC	NUM OF SVC	REVENUE/ PROCEDURE CODE	PAY- MENT CODE	PROVIDER CHARGE	MAJ MED ELIGIBLE AMOUNT	OUR ALLOWANCE	NON- CHARGEABLE AMOUNT	NON- CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
PATIENT ACCT #: xxxxxxxxxxxxxxxxx													
MEMBER ID: xxxxxxxxxxxxxxxxx													
PATIENT NAME: NAME													
MEMBER: NAME													
CLAIM NUMBER: 00000000000													
09/12/06	1	198942	001	55.00	54.50	54.50	10.50	25	10.90	CI		43.60	J0080
09/12/06	1	197140	001	25.00	25.00	25.00			5.00	CI		20.00	J0080
09/12/06	1	197032	001	30.00	30.00	30.00	10.00	25	4.00	CI		16.00	J0080
CLAIM TOTALS												79.60	
PATIENT ACCT #: xxxxxxxxxxxxxxxxx													
MEMBER ID: xxxxxxxxxxxxxxxxx													
PATIENT NAME: NAME													
MEMBER: NAME													
CLAIM NUMBER: 00000000000													
09/13/06	1	198942	023	55.00	52.00	52.00	3.00	25	10.00	DI		42.00	J0080
09/13/06	1	197530		30.00	30.00	30.00			30.00	H1		E5252, J0080	
09/13/06	1	197140	023	25.00	25.50	25.50	1.50	25	40.00			23.50	J0080
CLAIM TOTALS												65.50	
PATIENT ACCT #: xxxxxxxxxxxxxxxxx													
MEMBER ID: CONCURRENT MAJOR MEDICAL													
PATIENT NAME: NAME													
MEMBER: NAME													
CLAIM NUMBER: 00000000000													
09/01/06	1	199213	012	70.00	70.00	70.00			70.00	*		56.00	B5000A, J9040
CLAIM TOTALS												56.00	
CLAIM SPECIFIC MESSAGE(S):													
B5000A The patient's coverage does not provide for Home, Office or Outpatient Visit services. Therefore, no payment can be made.													
PATIENT ACCT #: xxxxxxxxxxxxxxxxx													
MEMBER ID: xxxxxxxxxxxxxxxxx													
PATIENT NAME: NAME													
MEMBER: NAME													
CLAIM NUMBER: 00000000000													
09/18/06	1	199213	001	60.00	60.00	60.00			12.00	CI		48.00	J0080

PF00000000

5.2 Example of Medicare Part B Supplemental EOB

 EXPLANATION OF BLUE SHIELD BENEFITS (COMPLEMENTS MEDICARE PART B)																																																												
X	PATIENT'S NAME/NUMBER	HEALTH INSURANCE CLAIM NUMBER/CONTROL NUMBER	PROCEDURE CODE	WHEN		Srv. Code	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	COINSUR.	DEDUCT.	TOTAL PAYMENT	MEDICARE PAYMENT	MEMBER ID/ GROUP NUMBER	BLUE SHIELD USE ONLY																																													
				FROM	TO																																																							
				Mo	Day	Yr																																																						
			99213	091	360	091	360	1	7500	4989	4989	000	998	000	998	39919	W0																																											
							CLAIM TOTALS		7500	4989	4989																																																	
<table border="1"> <tr> <td>TOTALS</td> <td>NUMBER OF CLAIMS</td> <td>AMOUNT CHARGED</td> <td>MEDICARE ALLOWED</td> <td>BLUE SHIELD ALLOWED</td> <td>MEDICARE DEDUCTIBLE</td> <td>BLUE SHIELD DEDUCTIBLE</td> <td>CO-INSURANCE</td> <td>DEDUCTIBLE</td> <td>TOTAL PAYMENT</td> <td>MEDICARE PAYMENT</td> </tr> <tr> <td>EOB --</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OFFSET --</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>SUMMARY</td> <td>CHECK NO.</td> <td>PAID DATE</td> <td>PAGE</td> <td colspan="7">CHECK TOTAL:</td> </tr> </table>																	TOTALS	NUMBER OF CLAIMS	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	MEDICARE DEDUCTIBLE	BLUE SHIELD DEDUCTIBLE	CO-INSURANCE	DEDUCTIBLE	TOTAL PAYMENT	MEDICARE PAYMENT	EOB --											OFFSET --											SUMMARY	CHECK NO.	PAID DATE	PAGE	CHECK TOTAL:						
TOTALS	NUMBER OF CLAIMS	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	MEDICARE DEDUCTIBLE	BLUE SHIELD DEDUCTIBLE	CO-INSURANCE	DEDUCTIBLE	TOTAL PAYMENT	MEDICARE PAYMENT																																																		
EOB --																																																												
OFFSET --																																																												
SUMMARY	CHECK NO.	PAID DATE	PAGE	CHECK TOTAL:																																																								

THIS IS NOT A BILL

5.2 Example of Medicare Part B Supplemental EOB, continued

THE ADDRESS FOR FILING MEDIGAP CLAIMS IS:

HIGHMARK BLUE SHIELD
P. O. BOX 898845
CAMP HILL, PA 17089-8845
1-866-763-6695

WHEN QUESTIONING CLAIM STATUS, BENEFITS, OR
ENROLLMENT INFORMATION, PLEASE USE INFOFAX AT
1-800-891-1856 OR OASIS AT 1-800-462-7474.



NAME
STE 000
STREET
CITY ST ZIP

13,439

5.2 Highmark's Internal Billing Dispute Process

Billing Dispute Process Overview

Any provider who treats a Highmark member has the right to dispute claims payment decisions made by Highmark. Highmark offers several ways for providers to express dissatisfaction with their claims payment or lack thereof.

Network providers may:

- *Call Provider Service*
- *Submit a NaviNet® Inquiry*
- *Send Written Correspondence to Customer Service*

It is the provider's responsibility to submit all necessary information about the billing dispute and any additional documentation. If Highmark determines there is incomplete information, the provider will be contacted to provide the necessary information.

Once all documentation is received, it is routed to the appropriate department for research and review. A service representative will review the applicable claim(s) and determine whether the claim(s) processed correctly. Individual departments within Highmark have varying levels of review and will notify the provider at various stages of the review, as applicable. In certain instances, internal billing dispute processes are considered final. In cases where eligibility requirements are met, further billing dispute resolution processes may be available.

No matter the outcome, each provider who submits a billing dispute will receive notification advising them of the outcome and the reason for the decision. Actions will be taken to remedy the billing dispute, if the provider's contention was correct.

Medical Review Committee

A dispute with a health services doctor (as defined in 40 Pa. C.S.A. Section 6302) which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration.

This review practice is further discussed in the Introduction of the Highmark Blue Shield Office Manual available on Highmark's Provider Resource Center under Administrative Reference Materials.
