Unit 13 Bill Type Adjustments and Claim Investigation

In this unit This brief unit provides instructions on adjusting claims that have already been submitted to Highmark Blue Shield.

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Unit 13 Bill Type Adjustments

In order to make changes to claims which have already been submitted to Highmark Blue Shield, providers will need to use the Adjustment Bill Types XX7, XX8, or XX5. These Adjustment Bill Types are to be used for both electronic and paper previously submitted claims. Please follow the specific guidelines provided in the table below for Adjustment Bill Types XX8, XX7, and XX5.

ADJUSTMENT BILL TYPE	WHEN TO UTILIZE	HIGHMARK ACTION
XX8 Void/Cancel Prior Claim	This code reflects the elimination in its <i>entirety</i> of a previously submitted bill. Use of XX8 will cause the bill to be completely cancelled from the Highmark Blue Shield System. <i>The facility has the option to initiate a</i> <i>NaviNet investigation to cancel a previously</i> <i>submitted claim.</i>	Void the original claim on the remit and provide the message of ANSI Code OA125: Payment adjusted due to submission/ billing error(s).
XX7 Replacement of Prior Claim	This code is to be used when a specific bill or line has been issued and needs to be restated in its entirety. When this code is used, Highmark Blue Shield will operate on the principle that the original bill is null and void, and that the information present on this bill represents a <u>complete</u> replacement of the previously issued bill.	Adjust the original claim by overlaying data from XX7 claim onto original claim. The new payment amount or retraction will be processed on the original claim. The XX7 claim will reject with ANSI Code OA125: Payment adjusted due to a submission/billing error(s).
XX5 Late Charges Only	This code is to be used for submitting additional new charges or lines which were identified by the facility after the original claim was submitted.	Adjust the original claim to include the additional charges. XX5 claim will reject with OA125: Payment adjusted due to submission/billing error(s).

PLEASE NOTE: THE ORIGINAL CLAIM NUMBER IS REQUIRED WHEN SUBMITTING ADJUSTMENT BILL TYPES XX8, XX7, AND XX5 ON UB CLAIMS VIA NAVINET UB CLAIM SUBMISSION AND HIPAA 837I BATCH SUBMISSION.

Unit 13 Investigating a Claim

Investigation	An investigation is the ordinary means facilities use to communicate their questions to Highmark Blue Shield regarding pending, paid or denied claims.
When investigation is appropriate	 Investigation is appropriate if any of the atypical situations listed below should occur: A claim has been pending for more than 45 days beyond the received date
	 A claim has been paid, but the facility questions the payment amount A claim is denied and the facility questions the denial reason
To initiate an investigation	Highmark Blue Shield's recommended method for initiating an investigation by providers is electronically via the NaviNet Claim Status function. If you do not have access to NaviNet, please contact Highmark Blue Shield Facility Customer Service, at (866) 803-3708 between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday.
	If contacting Facility Customer Service regarding your investigation, please be prepared to provide all pertinent information to the representative who receives your call.
ı E-	FOR INFORMATION ON CLAIM INVESTIGATION, PLEASE REFER TO THE NAVINET USER GUIDES.