Chapter 7. Billing and Claims Processing

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7.1 Electronic Claims Submission

7.1.1 How it Works

Highmark West Virginia strongly encourages providers to submit claims electronically. Instead of printing, bundling and sending paper claims through the mail, a provider can simply enter and store claims data in an electronic information system/computer. Then, as often as necessary, claim information can be transmitted by the provider or his/her chosen electronic billing vendor to Highmark West Virginia.

The required components for electronic claims submission are an information system/computer, an internet connection, and an appropriate software package.

7.1.2 Advantages

Some of the major benefits of electronic claims submission are:

- You save money on forms and postage.
- You save time. Paper claims can take 2-3 days to reach us through the postal system; once the claim is received, it must be scanned into our system and then hand keyed. Keypunch errors can occur.
- Electronic claims process faster than paper claims, generally 7-14 days compared to 21-27 days.
- Claims can be submitted 24 hours a day, 7 days a week.
- Up front edits notify you (generally within 24 hours) if a claim was not accepted into our system. This allows you or your vendor to correct the error and resubmit the claim electronically.
- Reports are generated to show you what claims were accepted into our system.
- You can receive your remittance advice electronically.
- You can have your check electronically deposited into your bank account.

7.1.3 How to Initiate

To get started or for more information, contact Highmark West Virginia Electronic Data Exchange (EDI) Operations at:

EDI Operations
Highmark Blue Cross Blue Shield West Virginia
P. O. Box 1948
Parkersburg, WV 26102-1948
Telephone: 1-888-222-5950
(304) 424-7728
Fax: (304) 424-9810
Email: msemc@highmark.com

You may also contact your External Provider Relations Representative.

Detailed information and specifications are contained in the Highmark West Virginia *Provider EDI Reference Guide*, which can be accessed on the Highmark West Virginia website at www.highmarkbcbswv.com. Click on the Provider tab then select "Resource Center" and click "EDI."

Highmark West Virginia's EDI system supports electronic transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires that procedures be established to secure access to data. Highmark West Virginia has a process to establish a Trading Partner relationship with providers who wish to submit claims electronically. A "Trading Partner" is any customer (e.g. provider, billing service) that transmits to or receives electronic data from Highmark West Virginia.

This process includes completing an *EDI Transaction Application* and executing an *EDI Trading Partner Agreement*. Once the agreement is received, the provider will be sent a logon ID and password combination for use when accessing Highmark West Virginia's EDI system. Highmark West Virginia requires testing of potential Trading Partners for each transaction included on the EDI transaction application. For detailed information and instructions please see Chapter 5 of the *Provider EDI Reference Guide*, which may be found on www.highmarkbcbswv.com by clicking on the Provider tab and then selecting "Resource Center."

After sign-up, a provider should have its Trading Partner number and logon ID available whenever contacting the Highmark West Virginia EDI Operations Office to facilitate faster handling of your questions.

The *EDI Transaction Application* and *EDI Trading Partner Agreement* are available on the Highmark West Virginia website in the same location as the *EDI Reference Guide.*

The Highmark West Virginia EDI Operations Office can provide you with a list of software vendors, clearinghouses and billing services that are already HIPAA transaction-ready with Highmark West Virginia.

7.1.4 Transactions Available

As mandated by HIPAA, electronic claims are submitted to Highmark West Virginia using either the 837 Professional (837P) or 837 Institutional (837I) health care claim transaction. Upon receipt of the 837 transaction, there are several acknowledgement transactions you can choose for tracking electronic claim submissions and payment, depending on the capabilities of your software. These include:

- **997 Functional Acknowledgement.** This transaction is available the same day you transmit your claims. The benefit of this transaction is that it provides the ability to confirm that your electronic claim file was either accepted or rejected by Highmark West Virginia EDI Operations.
- **277 Claim Acknowledgement.** This transaction is available approximately 24 hours after the 997 Functional Acknowledgement report is accepted. The 277 Claim Acknowledgement indicates whether claims were accepted for processing. For those claims not accepted, the transaction provides instructions for the submitter to correct and resubmit the claims. For submitters that are not able to interpret the 277 Claim Acknowledgement Transaction, a text format Claim Acknowledgement Report has been developed.
- **835 Electronic Remittance Advice.** The 835 transaction is used to send an electronic Explanation of Benefits remittance advice from a payor to the Trading Partner. Highmark West Virginia's 835 transactions are created on a weekly basis to correspond with our weekly payment cycles. The 835 transaction files become available for retrieval by the provider from the Trading Partner. This transaction contains finalized claim payment information used for automated account posting.

A more complete listing of the provider EDI transactions Highmark West Virginia supports is provided below:

Provider Transactions	
270 Transaction	Eligibility/Benefit Inquiry
271 Transaction	Eligibility or Benefit Information (response to 270)
276 Transaction	Claim Status Request
277 Transaction	Claim Status Notification (response to 276)
278 Transaction	Two implementations of this transaction: • Services Review – Request for Review (Referral/Authorization Request) • Services Review – Response to Request to Review

837 Transaction	Three implementations of this transaction: • Institutional • Professional • Dental
	NOTE: Dental transactions (837Ds) for Highmark West Virginia products must be sent to Highmark West Virginia's dental associate, United Concordia Companies Inc. (UCCI). To receive authorization to submit transactions to UCCI, you must contact Dental Electronic Services at 1-800-633-5430.
835 Transaction	Claim Payment/Advice (Electronic Remittance)
277 Acknowledgement	Claim Acknowledgement (Replaces Submission Summary Report)
997 Transaction	Functional Group Acknowledgement

7.1.5 NAIC Codes

Accurate reporting of NAIC codes to identify the appropriate payor and to control routing is critical for electronic claims submitted to Highmark West Virginia EDI. For all Highmark West Virginia and Blue Card products use NAIC code 54828.

West Virginia members covered under Highmark Health Insurance Company FreedomBlue, plan code 377, alpha prefix HQM (Medicare Advantage PPO) or HKP (Medicare Advantage Private Fee for Service) should be billed to 71768.

Other Blue Medicare Advantage PPO (MA PPO) plans that participate in reciprocal network sharing should be billed to NAIC code 71768. You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program.

NOTE: Use of this logo is not mandated until 2012. HHIC and some other Blue plans will be using the logo on ID cards in 2010. However, ID cards from several other Blue plans may not include the logo until 2012. Until the issuance of new ID cards by 2012, some ID cards may simply be worded as Medicare Advantage PPO.

Any other state's Medicare Advantage member who is covered under a Medicare Advantage Private Fee for Service (PFFS) should continue to be billed to 54828. The

only Medicare Advantage PFFS that should be billed to 71768 are West Virginia members PFFS alpha prefix HKP.

Claims billed to the incorrect NAIC code will reject on your 277CA report as A3>116, "CLAIM SUBMITTED TO THE INCORRECT PAYOR". If this rejection is received, please file your claim electronically to the correct NAIC code.

7.1.6 NaviNet[SM] Internet Transactions

In addition to the EDI transactions described in this section, Highmark West Virginia offers network providers an expanded and enhanced set of transactions to enable them to communicate with the company via the internet through our provider "portal," NaviNet[SM].

NaviNet[SM] is an internet-based system that makes information in Highmark West Virginia's systems available to providers in a real-time environment. Providers can verify eligibility and benefits, check on claim status, submit authorizations and perform many other functions that otherwise would require a telephone call, letter or fax.

For more information about NaviNet[SM], see Chapter 1 of this *Provider Manual*.

7.1.7 Electronic Funds Transfer

Electronic Funds Transfer ("EFT") is the direct deposit of Highmark West Virginia payments to the provider's bank account. For more information on EFT eligibility and enrollment, providers should contact their External Provider Relations Representative or call the Office of Provider Relations at 1-800-798-7768 or 1-304-424-7795.

7.1.8 EDI System Operating Hours

Highmark West Virginia is available to handle EDI transactions 24 hours a day, 7 days a week, except during scheduled system maintenance periods.

Highmark West Virginia EDI Trading Partners should transmit any test data during the hours that Highmark West Virginia EDI Operations support is available. These hours are 8:00 a.m. to 4:00 p.m. ET, Monday through Friday.

7.2 Where To Submit Claims

Highmark Blue Cross Blue Shield West Virginia
P O Box 7026
Wheeling, WV 26003

Please submit Blue Cross and Blue Shield claims to Highmark West Virginia at the above address for processing. If we cannot process the claims through the BlueCard® Program, we will forward them to the member's home plan. For more information on BlueCard®, see Section 7.6 of this *Provider Manual*.

Highmark Health Insurance Company
P O Box 7004
Wheeling, WV 26003

Please submit Medicare Advantage PPO Claims to the above address for processing including other states Medicare Advantage PPO plans who participate in reciprocal network sharing.

7.3 Claim Forms / Coding / Modifiers

7.3.1 Forms

Physicians, other professional and allied health providers, and laboratories must submit claims on a red CMS 1500 form (formerly HCFA 1500). The type of form (either UB or CMS 1500) required for ancillary providers varies by provider type. A complete listing of the required forms by type of ancillary provider can be found in Section 5.2.1 of this *Provider Manual*.

In order for a claim to be considered clean and to avoid delay or rejection, claims must be completed in accordance with applicable instructions and contain all information requested in every field of the claim.

NOTE - Effective January 2010 Highmark West Virginia implemented mandatory electronic claims filing for hospital facilities when billing for charges applicable on the UB format. This applies to both inpatient and outpatient services. Other facility providers who must bill a paper claim must submit all services on the current UB04 claim form.

7.3.2 Coding

Claims should be submitted on the appropriate type of form using the most appropriate and current diagnosis (ICD-9-CM), AMA CPT procedure codes, HCPCS codes for professional services, ASA procedure codes for anesthesia services, and UB-04 Revenue Codes to reflect the services provided.

7.3.3 Modifiers

Highmark West Virginia recognizes all CPT and HCPCS modifiers when used appropriately. All circumstances supporting the use of the modifier must be documented in the member's medical record.

Highmark West Virginia does not routinely require that medical records supporting use of a modifier be submitted along with the claim, except when Modifier 22 (unusual procedural services) is used. When Modifier 22 is used, the provider must submit supporting documentation with the claim that the service provided is greater than that usually required for the CPT procedure code billed.

Highmark West Virginia may identify other limited categories of claims for which it determines that routine submission of medical records with a claim is appropriate. Highmark West Virginia will post notice of any such requirement in the Provider section of our website, www.highmarkbcbswv.com, at least 90 days in advance of the change.

Our medical policies may address use of a particular modifier and any required record submission in connection with billing for the service or services addressed in the medical policy. Our medical policies are published on our website and may be searched by key word (e.g. anesthesia), type of service (e.g. radiology) or through an alphabetical index. For more information see Section 6.6 of this *Provider Manual.*

Highmark West Virginia may require the submission of medical records before or after payment of claims for the purpose of investigating potentially fraudulent, excessive, abusive or other inappropriate billing practices. We reserve the right to perform retrospective audits to verify the appropriate use of modifiers (e.g. Modifier 25).

Use of a particular modifier will not automatically override all clinical edits integrated into the claims payment system and will not supersede benefit limits or exclusions. If payment for a service submitted with a modifier is denied or reduced and the provider disagrees with the payment determination, then the provider should submit supporting documentation from the medical record together with any appeal.

Nothing in this section is intended to limit Highmark West Virginia's right to require or request the submission of medical records in connection with precertification or prior authorization of services. (See Chapter 6 of this *Provider Manual*.)

7.3.4 Clinical Information

Certain edits within Highmark West Virginia's processing system may require the submission of additional clinical information, in addition to the diagnosis(es) reported on the claim.

These include:

- Potentially cosmetic procedures;
- Procedures of questionable current usefulness; and
- Individual consideration.

Providers requesting a rejected claim to be re-considered for payment should submit clinical information to support payment of rejected services.

7.4 Provider ID / National Provider Identifier

The National Provider Identifier ("NPI") is a Health Insurance Portability and Accountability Act ("HIPAA") Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standard transactions.

Highmark West Virginia will reject electronic claim submissions that don't contain an NPI in the biller, rendering provider and service facility field and will return the claims to the provider. Additionally, Highmark West Virginia will reject electronic inquiry transactions – such as eligibility, authorization and claims status inquiries – that do not contain and NPI.

As outlined in the federal regulation (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Healthcare providers who bill for services probably need an NPI. If one bills Medicare for services, he/she definitely needs an NPI. Getting an NPI is easy and it is free. The first step is to get an NPI. Delays can risk cash flow, and jeopardize patient services. Call 1-800-465-3203 to learn more, or visit CMS' website at www.cms.hhs.gov/NationalProvIdentStand/03apply.asp

NPI Frequently Asked Questions ("FAQs") and other valuable NPI resources are available for perusal and downloading on the CMS web site at www.cms.hhs.gov/NationalProvIdentStand

7.5 Timely Filing

7.5.1 When We are Primary

When Highmark West Virginia is the primary payor, a provider must submit a claim within 12 months after the date the service is provided or the date the member is discharged from the hospital or other facility, unless the member's policy provides otherwise. Claims submitted beyond these timelines will be denied.

If a provider initially submits a claim within the timely filing period and Highmark West Virginia requests additional information, then the provider must submit the requested information within 30 days, or before expiration of the timely filing period, whichever is longer. If the requested information is not submitted timely, the claim will be denied and both Highmark West Virginia and the member are held harmless, except for any applicable copays, coinsurance or deductibles.

Late charges must be submitted within the timely filing period or they will be denied.

If a claim is denied for failure to meet timely filing requirements, the provider must hold both Highmark West Virginia and the member harmless.

7.5.2 When We Are Secondary

When Highmark West Virginia is a secondary payor, a provider must submit a claim within 12 months after the date the primary payor adjudicated the claim, unless the member's policy provides for a different period. The provider must attach to the claim an Explanation of Benefits documenting the date the primary payor adjudicated the claim. Secondary claims not submitted within the timely filing period will be denied and both Highmark West Virginia and the member held harmless. Electronically enabled providers should submit secondary claims electronically using the proper CAS code segments.

When it is known or there is reason to believe that other coverage exists, claims are not paid until the other carrier's liability has been investigated. Highmark West Virginia may send a letter/questionnaire to the covered person. If the covered person responds to the letter/questionnaire indicating that he/she is covered by additional policies, the records are marked to indicate that other carrier information is required in order to complete claims processing when the other carrier's policy is primary. If the covered person does not respond promptly to Highmark West Virginia's request for information, Highmark

West Virginia will deny claim payment using a remark code indicating the covered person is responsible. (FEP claims are not denied but are pended until a response is received from the covered person. Highmark West Virginia will not provide benefits for these FEP claims until a response is received.) The provider may seek reimbursement from the covered person.

7.5.3 Special Circumstances for Terminated Self-Funded Accounts

Upon termination of a self-funded group, Highmark West Virginia will continue to process claims for a period of time as specified in the terminated self-funded account's contract. This is otherwise referred to as a "run-out period." Often the run-out period is less than 12 months, and claims received after this period will be denied.

7.5.4 Investigation of Other Coverage

If we have reason to believe that a member might have other coverage, we may pend a claim to allow us to investigate whether such coverage exists and, if so, determine which coverage is primary. Highmark West Virginia may send a questionnaire to the member inquiring about other coverage. If the member does not respond within the requested timeframe, Highmark West Virginia may deny the claim and indicate that the member is responsible for payment.

7.5.5 Locum Tenens

Highmark West Virginia will permit Locum Tenens providers to submit claims for services provided during a physician's leave of absence from his or her practice. Highmark West Virginia must be notified of any Locum Tenens arrangement in advance, when possible.

This arrangement is limited to a 6-month continuous period. The licensed provider acting in a Locum Tenens role must submit claims under the provider ID number(s) of the physician on leave of absence. Modifier Q6 must be submitted on the claim to identify services provided the Locum Tenens physician.

During this time the Locum Tenens will not be required to go through the initial credentialing process. Provider arrangements as Locum Tenens beyond the 6 months will require full credentialing of the physician. Please contact Highmark West Virginia in advance if the arrangement will extend beyond 6 months to ensure timely credentialing approval for network participation.

For credentialing requirements please refer to Chapter 3.3.3.

7.6 BlueCard® Program

7.6.1 What is BlueCard®?

BlueCard® is a national program that enables members of one Blue Cross or Blue Shield plan to obtain health benefits while traveling or living in another Blue plan's service area. The program links network health care providers with the independent Blue Cross and Blue Shield plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

As a network provider with Highmark West Virginia, BlueCard® lets you submit claims for patients who are members of other Blue plans, domestic and international, to Highmark West Virginia as your local Blue plan. Highmark West Virginia serves as your primary point of contact for claims payment and other claims-related questions.

7.6.2 BlueCard® Program Provider Manual

A detailed *BlueCard® Program Provider Manual* can be accessed on the Highmark West Virginia website at www.highmarkbcbswv.com on the Provider tab under "Resource Center." The manual offers helpful information about:

- Identifying members;
- Verifying eligibility;
- Obtaining precertification or preauthorization;
- Filing claims; and
- Who to contact with questions.

Because of the strong likelihood that you will provide services to members of other Blue plans, you are encouraged to familiarize yourself with the *BlueCard® Program Provider Manual* and the rules governing this program.

If you have questions about the BlueCard® program, please contact your External Provider Relations Representative or call the Office of Provider Relations at 1-800-798-7768 or 1-304-424-7795. For questions related to specific claims, please contact Highmark West Virginia Customer Service at 1-800-543-7822.

7.6.3 Border County Providers

BlueCard® claim submission rules are different for Highmark West Virginia network providers located in counties contiguous to West Virginia (other than Washington County, Ohio, which is part of Highmark West Virginia's service area). These providers generally must submit claims for members of Blue plans other than Highmark West Virginia to the local Blue plan for the county in which the provider is located. Claims for Highmark West Virginia members should always be submitted to Highmark West Virginia. Please consult the *BlueCard® Program Provider Manual* for more specific information.

7.7 Claim Inquiries

For questions about a particular claim, providers should contact Highmark West Virginia Customer Service at the appropriate number listed below.

Claims Customer Service – Parkersburg	(888) 809-9121 or (304) 424-7701
Claims Customer Service – Wheeling	(800) 654-5028 or (304) 234-7012
FEP Customer Service – Parkersburg	(800) 535-5266 or (304) 424-7792
FreedomBlue® Customer Service	(888) 459-4020

Normal business hours are **8 a.m. to 4 p.m**., Monday through Friday for local and FEP business.

When contacting Customer Service, please have the following information available:

- Member's name;
- ID number;
- Patient's name;
- Provider ID number;
- Date of service; and
- Provider's charge.

Written inquiries should be sent to:

Highmark Blue Cross Blue Shield West Virginia
P. O. Box 7026
Wheeling, WV 26003

Providers may also inquire about the status of a claim electronically via NaviNet[SM] or EDI transaction. See Section 7.1 of this *Provider Manual*.

7.8 Adjustment of Incorrect Payments

A demand for repayment or an adjustment of an overpayment will generally be initiated by Highmark West Virginia within two years after the date of claim payment. **(See exceptions for MDs and DOs in Chapter 13 of this *Provider Manual*.)** This two-year limit does not apply to claims that:

- Were submitted fraudulently;
- Contain material misrepresentations;
- Represent a pattern of abuse or intentional misconduct;
- Are for certain self-funded plans where Highmark West Virginia acts as a third party administrator;
- Involve Workers' Compensation exclusions or subrogation;
- Are subject to a different recovery period under federal or state law (other than FEP, which is subject to the guidelines of this section);
- Involve a good faith dispute about the legitimacy of the amount of the claim (e.g. disputed audit findings during the resolution process);
- Are where Highmark West Virginia's failure to comply with the time limit is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond its reasonable control (e.g. fire, pandemic flu); or
- Are where the provider is obligated by law or other reason to return payment to Highmark West Virginia or a Highmark West Virginia member (e.g. Unclaimed Property Act).

Note: **A one-year limit applies to certain insured retroactive denials under Section 7.11.7 of this *Provider Manual*.**

7.9 Appeals

For challenges to appeals of medical payment adequacy and amount, see Section 6.4 of this *Provider Manual*.

7.10 Self-Funded Accounts

Highmark West Virginia acts *only* as a third party administrator for a self-funded benefit plan (i.e. the benefits are not insured by us and our services are administrative only). We shall not be required to pay a provider's claim for services rendered to a member of the

self-funded plan unless and until the self-funded plan pays or reimburses Highmark West Virginia for the amount of the claim and the administrative cost to process and pay the claim. Highmark West Virginia does not insure, underwrite or guarantee the responsibility or liability of any self-funded plan to provide benefits or to make or administer payments.

If a self-funded plan fails to provide payment or reimbursement to Highmark West Virginia to fund claims (whether such claims have been paid already by Highmark West Virginia or not), then a provider shall not hold Highmark West Virginia liable, but must look to the self-funded plan or the patient for payment. Highmark West Virginia may demand the return of any payment to the provider, or may set off against amounts owed to the provider, for any claims for which a self-funded plan fails to make payment or reimbursement to Highmark West Virginia.

Member ID cards identify members of self-funded accounts. Providers may contact Highmark West Virginia Customer Service at the telephone number on the back of the card to inquire about the current eligibility status of the member, or contact the Office of Provider Relations at 1-800-798-7768 with questions regarding the current funding status of a self-funded account.

7.11 West Virginia Prompt Pay Act

7.11.1 Applicability

The Ethics and Fairness In Insurer Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the "Prompt Pay Act" ("the Act"), applies to health insurance contracts insured by Highmark West Virginia, with certain exceptions. For claims subject to the Act, Highmark West Virginia adheres to the standards for processing and payment of claims established by the Act. These standards are summarized in this Section 7.11 or are addressed in other parts of this *Provider Manual*.

The Act does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To providers outside of West Virginia;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, Medicare Supplemental and PEIA;
- To most self-funded plans where Highmark West Virginia acts as a third party administrator;
- To BlueCard® claims;
- To claims that are not covered under the terms of the applicable health plan (e.g. Workers' Compensation exclusions);
- When there is a good faith dispute about the legitimacy of the amount of the claim;

- When there is a reasonable basis, supported by specific information, that a claim was submitted fraudulently or with material misrepresentation; or
- Where Highmark West Virginia's failure to comply is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond our reasonable control.

7.11.2 Payment of Clean Claims

Highmark West Virginia will generally either pay or deny a clean claim subject to the Act within 40 days of receipt if submitted manually, or 30 days if submitted electronically, except in the following circumstances:

- Another payor or party is responsible for the claim;
- We are coordinating benefits with another payor;
- The provider has already been paid for the claim;
- The claim was submitted fraudulently; or
- There was a material misrepresentation in the claim.

A "clean claim" means a claim: (1) that has no material defect or impropriety, including all reasonably required information and substantiating documentation to determine eligibility or to adjudicate the claim; or (2) with respect to which Highmark West Virginia has not timely notified the person submitting the claim of any such defect or impropriety in accordance with Section 7.11.4 below.

See Chapter 13 of this *Provider Manual* for additional requirements for MDs and DOs.

7.11.3 Record of Claim Receipt

Highmark West Virginia maintains a written or electronic record of the date of receipt of a claim. The person submitting the claim may inspect the record on request and may rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If we fail to maintain such a record, the claim will be considered received three business days after it was submitted, based upon the written or electronic record of the date of submittal by the person submitting the claim.

7.11.4 Requests for Additional Information

For claims subject to the Act, if Highmark West Virginia reasonably believes that information or documentation is required to process a claim or determine if it is a clean claim, then we will:

- Request such information within 30 days after receipt of the claim;
- Use all reasonable efforts to ask for all desired information in one request;
- If necessary, make only one additional request for information;
- Make such additional request within 15 days after receiving the information from the first request; or
- Make the second request only if the information could not have been reasonably identified at the time of the original request or if there was a material failure to provide the information initially requested.

Upon receipt of the information requested, we will either pay or deny the claim within 30 days.

We cannot refuse to pay a claim for covered benefits if we fail to request needed information within 30 days of receipt of the claim, unless this failure was caused in material part by the person submitting the claim. Highmark West Virginia is not precluded from imposing a retroactive denial of payment of such a claim, unless this denial would be in conflict with the Act's standards on retroactive denials.

7.11.5 Interest

For clean claims subject to the Act that are not paid within 40 days, Highmark West Virginia will pay interest, at the rate of 10% per year, on clean claims, accruing after the 40th day. We will provide an explanation of the interest assessed at the time the claim is paid.

See Chapter 13 of this *Provider Manual* for additional requirements for MDs and DOs.

7.11.6 Limitation on Denial of Claims Where Authorization, Eligibility and Coverage Verified

Under the terms of its health plan contracts, Highmark West Virginia will reimburse for a health care service only if:

- The service is a covered service under the member's plan;
- The member is eligible on the date of service;
- The service is medically necessary; and
- Another party or payor is not responsible for payment.

If Highmark West Virginia advises a provider or member in advance of the provision of a service that: (1) the service is covered under the member's plan; (2) the member is

eligible; AND (3) via pre-certification or pre-authorization, the service is medically necessary, then we will pay a clean claim under the Act for the service unless:

- The claim documentation clearly fails to support the claim as originally pre-certified or pre-authorized;
- Another payor or party is responsible for the payment;
- The provider has already been paid for the service;
- The claim was submitted fraudulently or the pre-certification or pre-authorization was based in whole or material part on erroneous information provided by the provider, member or other person not related to Highmark West Virginia;
- The patient was not eligible on the date of service and Highmark West Virginia did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;
- There is a dispute regarding the amount of the charges submitted; or
- The service provided was not a covered service and Highmark West Virginia did not know, and with the exercise of reasonable care could not have known, at the time of the verification that the service was not covered.

7.11.7 Retroactive Denials

Under the Act, Highmark West Virginia may retroactively deny an entire previously paid claim insured by Highmark West Virginia for a period of one year from the date the claim was originally paid. Section 7.8 of this *Provider Manual* addresses time limits and related exceptions for retroactive negative adjustments. The Act and its one-year time limit does not apply:

- To services furnished by providers not contracted with Highmark West Virginia;
- To contracted providers outside of West Virginia;
- To claims paid under an ERISA self-funded plan;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage and PEIA;
- When a good faith dispute about the legitimacy of the amount of the claim is involved (e.g. disputed audit findings during the resolution process);
- Where Highmark West Virginia's failure to comply with the time limit is caused in material part by the person submitting the claim or Highmark West Virginia's compliance is rendered impossible due to matters beyond its reasonable control (e.g. fire, pandemic flu);
- Where the provider is obligated by law or other reason to return payment to Highmark West Virginia or a Highmark West Virginia member (e.g. Unclaimed Property Act);
- To BlueCard claims; or
- To claims that are not covered under the terms of the applicable health plan (e.g. Workers' Compensation exclusions).

The two-year limit described in Section 7.8 of this *Provider Manual* will apply to the above exceptions unless otherwise excepted under that section. See an additional 18-month recovery limit in Section 13 of this *Provider Manual* for MDs and DOs.

Provider Recovery Process

Upon receipt of a retroactive denial under this Section 7.11, the provider has 40 days to either: (1) notify Highmark West Virginia of the provider's intent to reimburse the plan; or (2) request a written explanation of the reason for the denial.

Upon receipt of an explanation, a provider must: (1) reimburse Highmark West Virginia within 30 days; or (2) provide written notice that the provider disputes the denial. The provider should state reasons for disputing the denial and include any supporting information or documentation.

Highmark West Virginia will notify the provider of its final decision within 30 days after receipt of the provider's notice of dispute. If the retroactive denial is upheld, the provider must pay the amount due within 30 days or the amount will be offset against future payments.