* HIGHMARK WEST VIRGINIA AND HHIC NOW ACCEPT AND RETURN ELECTRONIC INQUIRY TRANSACTIONS IN VERSION 5010 *

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TO: (1) CHIEF FINANCIAL OFFICER
(2) DIRECTOR/MANAGER OF PATIENT ACCOUNTS
(3) BILLING OFFICE STAFF
(4) ADMISSIONS/REGISTRATION STAFF
(5) CARE/CASE MANAGEMENT OR UTILIZATION REVIEW STAFF
(6) DIRECTOR OF INFORMATION SYSTEMS

FROM: HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA (HIGHMARK WEST VIRGINIA) PROVIDER RELATIONS

SUBJECT: HIGHMARK WEST VIRGINIA AND HHIC NOW ACCEPT AND RETURN ELECTRONIC INQUIRY TRANSACTIONS IN VERSION 5010

REFERENCE:

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PURPOSE

This bulletin notifies facility providers that as mandated by the Blue Cross and Blue Shield Association, Highmark West Virginia and Highmark Health Insurance Company (HHIC) now accept and return electronic inquiry transactions in HIPAA Version 005010 ("Version 5010") format.

BACKGROUND/OVERVIEW

Effective July 1, 2011, Highmark West Virginia and HHIC are able to accept and return the following electronic inquiry transactions in Version 5010:

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

Until December 31, 2011, Highmark West Virginia and HHIC will continue to accept and return these transactions in Version 4010 as well as in 5010. After that date, however, only 5010 transactions will be accepted or returned.

Provider Experience of Changes Associated with Transition of Inquiry Transactions to Version 5010 Will Vary

As always, the degree to which a provider will experience the changes described in the sections below depends upon the approach taken by the software vendor or clearinghouse through which its transactions are submitted to Highmark West Virginia and HHIC. Providers will need to discuss the information below with their trading partners, in order to know what to expect when they transition their electronic inquiries to Version 5010.

Changes Associated with the 270/271 Benefit Eligibility Inquiry Transaction

A New Definition of "Subscriber"

Currently, Highmark West Virginia and HHIC define the Subscriber as the person who holds the contract with Highmark West Virginia or HHIC. **Under Version 5010**, the Subscriber is defined as **a person who has a unique identification (ID) number.** This may not be the definition that is operative in the way a facility categorizes its patients for billing and inquiry purposes. Providers may wish to consider carefully whether this change will impact any of their business practices.

The "Alternate Search" Requirement

Today, in Version 4010, Highmark West Virginia and HHIC require three of the following four elements in order to identify a patient in response to a 270 transaction: member ID, member first name, member last name and date of birth.

For 270 transactions in Version 5010, payors must attempt to identify a patient using either of the following combinations of data: 1) the member ID, patient's first name and patient's last name; 2) the member ID, patient's last name and date of birth.

While Highmark West Virginia and HHIC are in compliance with this requirement, providers are reminded that the accuracy of member search functions always improves when more identifying information is provided. Facilities may wish to discuss with their vendors the demographic elements that will be passed in the 5010 270 transaction, to best support accurate patient identification results.

More Specific/Extensive Inquiry Results

Under Version 5010, payors such as Highmark West Virginia and HHIC will need to perform a more extensive electronic search in response to the provider's Inquiry transaction.

- Today, if the provider submits a **Version 4010** electronic inquiry for a patient named George as the Subscriber, but George is actually the Spouse, Highmark West Virginia and HHIC return a response indicating that coverage for George as the Subscriber is not found.

- If the provider submits a **Version 5010** electronic inquiry for George as the Subscriber (when he is actually the Spouse), Highmark West Virginia and HHIC must return a response

indicating that there is coverage for George as the Spouse under Martha, the Subscriber.

Availability of More Service Type Codes

Service Type Codes identify the specific category/categories of service for which the provider is requesting benefit eligibility information via its 270 transaction. Although a wide variety of Service Type Codes are already available for this purpose, approximately 30 additional Service Type Codes will be available when the provider transitions its Inquiry transactions to Version 5010.

Providers typically request benefit eligibility information for the specific type(s) of service the patient is to receive, using the appropriate Service Type Code(s). However, for various reasons -- including the technical parameters of its vendor or a situation in which the services to be provided are not fully determined at the time of the inquiry -- a provider may submit a generic benefits request using Service Type Code 30. In response to such a request in Version 5010, payors such as Highmark West Virginia and HHIC must provide information about ten specific service types, including any copayment/coinsurance, deductible, out-of-pocket amounts and limitations associated with each.

The complete list of Service Type Codes used in the 270/271 transaction is maintained by the Washington Publishing Company and can be accessed by contacting that company at www.wpc-edi.com.

Changes Associated with the 276/277 Healthcare Claim Status Request and Response Transactions ("the 276/277 Transactions")

Providers can use the 276 Healthcare Claim Status Request transaction to inquire about the status of a submitted claim.

- For finalized claims, the 277 Healthcare Claim Status Response transaction will provide status information at both the claim level and the line level.

- For pending claims, only claim-level status will be provided via this transaction.

Please note that responses received from other Blue Plans may vary in the level of detail or code usage from what Highmark West Virginia and HHIC provide.

The 277 transaction provides basic information about the claim(s) in question, including, as applicable, the amount of the payment and the check number. The more detailed information providers need for posting payments is communicated via the 835 remittance transaction.

Version 5010 has streamlined the information required for requesting claim status. To avoid unnecessary transmission of Protected Health Information, data that are not necessary for identifying the claim(s) in question (e.g., the Medical Records Number) will no longer be required in the 276 transaction. In addition, providers will find tracking their claim responses simpler in Version 5010 because there is a specific element for returning the Patient Control Number that was submitted on the claim for which status information is being provided.

Changes Associated With the 278 Healthcare Services Request for Review and Response Transaction ("the 278 Transaction")
The 278 transaction is used to verify medical necessity of health care services. In Version 5010, this transaction has been made much more robust than in the preceding Version, supplying all the information providers need to request and receive the payor's determination of medical necessity for a service to be rendered. Providers can utilize the 278 transaction to ascertain the medical necessity of a "patient event" such as an inpatient admission, as well as the medical necessity of services to be rendered while the member is an inpatient. The 278 transaction can be requested or received in batch mode or in real time.

IMPACT/ACTION

According to HIPAA regulations, all claim, remittance, eligibility and claim status transactions must be in Version 5010 by January 1, 2012. Providers that submit claims and inquiries directly to Highmark West Virginia and HHIC or through Trading Partners other than NaviNet should check with their Information Systems department or Trading Partner to ensure that they will be migrated to the new Version in advance of that deadline.

TIME FRAME

Providers must be ready to transmit all electronic claim, remittance, eligibility and claim status transactions in Version 5010 by January 1, 2012.

The inquiry capabilities described in this bulletin become available to providers once they transition to Version 5010. Highmark West Virginia and HHIC have been able to accept and return HIPAA 5010-compliant inquiry transactions since July 1, 2011.

ASSISTANCE

This Bulletin
For questions regarding this bulletin, please contact your assigned External Provider Relations Representative.

Inquiries about Eligibility, Benefits, Claim Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark West Virginia and HHIC encourage providers to use the electronic resources available to them – NaviNet® and the applicable HIPAA transactions – prior to placing a telephone call to the Customer Service Center.

provides a secure, Web-based portal between providers and health care insurance plans.