Highmark Delaware HEALTH OPTIONS

HHO OUTPATIENT CLAIMS EOB SUBMISSION REQUIREMENTS

Last Updated: July 31, 2020

PAYMENT POLICY	
Policy Name:	HHO Outpatient Claims EOB COB Submission Requirement
Policy Number:	HHO-MP-04
Approved By:	Joanne Landry; Dwayne Parker
Provider Notice Date:	7/31/2020
Original Effective Date:	7/31/2020
Annual Approval Date:	Annually on 8/1
Last Revision Date	7/31/2020
Products:	Highmark Health Options Delaware Medicaid
Application:	All participating and non-participating practitioners and facilities unless contractually precluded
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Disclaimer

Highmark Health Options' medical claims payment and prior-authorization policy is a reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical necessity decisions.

POLICY SCOPE:

This Highmark Health Options (HHO) policy is intended for Providers submitting claims for outpatient services (all services not provided in an inpatient place of service) when HHO is secondary payer. It is the expectation of HHO that all outpatient services are to be billed at the line level to support coordination of benefits and accurate claims processing. Outpatient services claims received without line level EOB/remit detail information will be rejected and must be resubmitted with the correct information.

On 7/31/2020, HHO Provider Relations provided 90 day notification of this policy requiring line level EOB/Remittance Advice COB information to be effective for outpatient claims submissions made on or after 11/1/2020.

HHO REQUIREMENTS:

HHO requires that claims be submitted based on regulatory requirements (*ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, 2006*).

HHO Requires:

- Claims must be submitted in a manner that ensures internal claim integrity
- Amounts reported in the 837 claim record MUST balance at two different levels – the claim level and the service line level
- Insurance details are to be added at the claim service line level

Important to Note:

- The Other Insurance Reasons Amounts plus the COB Payer Paid Amount must equal the charge amount of the claim detail line
- The COB Payer Paid Amounts on each service detail line together must equal the COB Payer Amount entered on the Other Insurance Details entered in the claim header

DEFINITIONS:

EOB/Remittance Advice: The support or advice received by the provider from the primary carrier that provides line level detail on how the primary carrier processed the claim. This will include paid and denied amounts and related CARC codes.

CARC Codes: Claim adjustment reason codes

REFERENCES:

- ASC X12 Standards for Electronic Data Interchange; Technical Report Type 3, 2006.

POLICY UPDATE HISTORY INFORMATION:

7/31/2020	Approved by HHO Leadership