CHAPTER 2: PRODUCT INFORMATION

UNIT 6: THE BLUECARD PROGRAM

This does not apply to Highmark Blue Cross Blue Shield of Western New York or Highmark Blue Shield of Northeastern New York at this time.

IN THIS UNIT

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, New York, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **NY ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in New York and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

2.6 INTRODUCTION

Why blue italics?

Overview

The *35* independent, community-based and locally operated Blue Cross and Blue Shield companies and the Blue Cross and Blue Shield Association (BCBSA) comprise the Blue Cross® and Blue Shield® System, the nation's oldest and largest family of health benefits companies. The Blues® cover 100 million Americans in all 50 states, the District of Columbia, and Puerto Rico. Nationwide, more than 96% of hospitals and 91% of professional providers contract with the Blue System — more than any other health insurer.

Offering a variety of products, programs, and services to all segments of the population, the Blues cover large employer groups, small business, and individuals. Moreover, the Blues have enrolled more than half of all U.S. federal workers, retirees, and their families, making the Federal Employee Program (FEP) the largest single health plan group in the world.

As a participating provider of Highmark, you may render services to patients who are members of other Blue Plans traveling to or living in Pennsylvania, Delaware, and West Virginia.

In this unit

This unit describes the BlueCard Program and its advantages, and provides information to make filing claims easy. You will find helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining precertifications/preauthorizations
- Filing claims
- Who to contact with questions

2.6 WHAT IS THE BLUECARD PROGRAM?

Definition

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

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan. Highmark is your sole contact for claim submission, payment, adjustments, and issue resolution.

Advantages for providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Highmark. Highmark will be your one point of contact for all of your claims-related questions.

Always look to Highmark first when you need help with information about out-of-area members. We are committed to meeting your needs and expectations. In doing so, your out-of-area Blue Plan patients will have a positive experience with each visit.

What Is My Service Area?

Highmark networks supporting BlueCard

The BlueCard Program is supported by Highmark's networks as follows:

PENNSYLVANIA

- **Participating Provider Network:** Supports all BlueCard programs for members with traditional, POS, or HMO coverage who are traveling or living outside of their Blue Plan's service area.
- **Keystone Health Plan West (KHPW)*:** The KHPW network supports the BlueCard PPO programs in the 29-county Western Region of Pennsylvania for members in a PPO plan who are traveling or living outside of their Blue Plan's service area.
- **Premier Blue Shield Network:** The Premier Blue Shield Network supports the BlueCard PPO programs in all other Highmark service areas in Pennsylvania for members in a PPO plan who are traveling or living outside of their Blue Plan's service area.

DELAWARE: The Delaware Provider Network supports the BlueCard Program.

**Keystone Health Plan West is Highmark's managed care provider network in the 29-county Western Region of Pennsylvania.*

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2.6 WHAT IS THE BLUECARD PROGRAM?, Continued

Highmark networks supporting BlueCard (continued)

WEST VIRGINIA

- **Indemnity Network:** Supports the BlueCard programs for members with traditional or HMO coverage who are traveling or living outside of their Blue Plan's area.
- **Preferred Provider Organization (PPO) Network:** Supports the BlueCard PPO programs for members in a PPO plan who are traveling or living outside of their Blue Plan's service area.
- **Point of Service (POS) Network:** Supports the BlueCard POS programs for members in a POS plan who are traveling or living outside of their Blue Plan's service area.

What Is My Service Area?

BlueCard Program exclusions

Claims for the following products are excluded from the BlueCard Program:

- Stand-alone dental
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Vision delivered through an intermediary model (using a vendor)
- The Federal Employee Program (FEP)*
- Medicare Advantage**

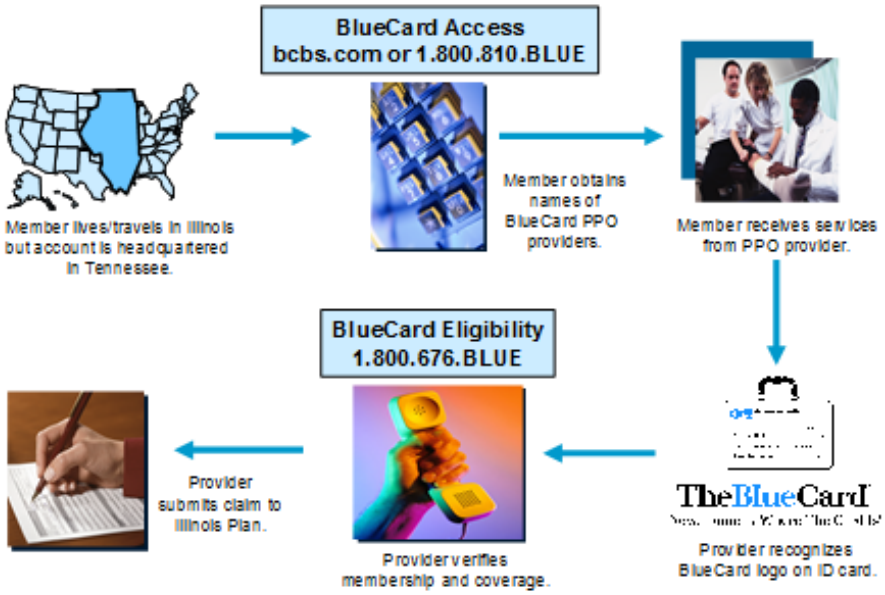
For more information on FEP, please visit the manual's* **Chapter 2.3: Other Government Programs *and for billing tips, see* **Chapter 6.4: Professional (1500/837P) Reporting Tips**.

Medicare Advantage is a separate program from BlueCard and delivered through its own centrally-administered platform; however, since you may see members of other Blue Plans who have Medicare Advantage coverage, Medicare Advantage information is available in this unit.

2.6 HOW THE PROGRAM WORKS: AN EXAMPLE

Example situation

The following diagram illustrates how the BlueCard® program works. In this example, a member with coverage through BlueCross BlueShield of Tennessee is seeking services in Illinois.



There are two scenarios where a Tennessee member might need to see a provider in the Illinois Blue Plan's service area:

1. If the Tennessee member was traveling in Illinois; or
2. If the member resides in Illinois and has employer-provided coverage through BlueCross BlueShield of Tennessee.

How the member can find participating providers

In either scenario above, the member can obtain the names and contact information for BlueCard PPO providers in Illinois by calling the BlueCard Access Line at **1-800-810-BLUE (2583)**.

The member also can obtain information online by using the *BlueCard National Doctor and Hospital Finder* available at **bcbs.com**.

Note: Although members are not obligated to identify participating providers through either of these methods, it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits.

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2.6 HOW THE PROGRAM WORKS: AN EXAMPLE, Continued

How a provider verifies the member's eligibility and benefits	When the member makes an appointment and/or sees an Illinois BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility Line at **1-800-676-BLUE (2583)**. The provider may also obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue Cross and Blue Shield of Illinois.
Claim submission and payment	After rendering services, the provider in Illinois files a claim locally with Blue Cross and Blue Shield of Illinois. The Illinois Blue Plan forwards the claim internally to BlueCross BlueShield of Tennessee. The Tennessee Blue Plan adjudicates the claim according to the member's benefits and the provider's arrangement with the Illinois Plan. This information is sent back to Blue Cross and Blue Shield of Illinois. When the claim is finalized, the Tennessee Plan issues an explanation of benefit (EOB) to its member. The Illinois Plan issues the explanation of payment or remittance advice to its provider and pays the provider.

2.6 HOW TO IDENTIFY BLUECARD MEMBERS

Member identification numbers

When members of out-of-area Blue Plans arrive at your office, be sure to ask them for their current Blue Plan membership identification card. The card will display the member's identification number.

Important facts concerning Member IDs:

- The main identifier for out-of-area members is the prefix.
- A correct Member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numerals/letters following the prefix.
- Do not add/delete characters or numerals within the Member ID.
- Do not make up prefixes.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

Do not assume that the member's ID number is the social security number. All Blue Plans have replaced Social Security numbers on Member ID cards with an alternate, unique identifier.

Note: Members who are part of the Blue Cross Blue Shield Federal Employee Program (FEP), which is excluded from BlueCard, will have the letter "R" in front of their Member ID number instead of a 3-character prefix.

Prefix (formerly "alpha prefix")

The 3-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

The 3-character prefix has historically been an "alpha prefix" – with all alpha characters. Beginning in 2018, the Blue Cross Blue Shield Association (BCBSA) will issue alphanumeric "prefixes" to Blue Plans since the options for 3-character all alpha combinations are running low. The examples below illustrate the alpha and alphanumeric prefixes on the Member ID card (A = alpha; N = numeric):

Continued on next page

2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

Prefix (formerly "alpha prefix") (continued)

There will be no change to existing 3-character alpha prefixes for products/accounts already in existence. Alphanumeric prefixes will be created and assigned to Blue Plans for new products or new large national group accounts.

Examples of Member ID numbers

The following examples represent various numeral/letter combinations that may be seen as Member IDs for Blue Plan members ((A = alpha; N = numeric):

Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the Member ID.

Helpful tips

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility Line at 1-**800-676-BLUE** to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Capture all ID card data to ensure accurate claim processing. If the information is not captured correctly, you may experience a delay with the claim processing.

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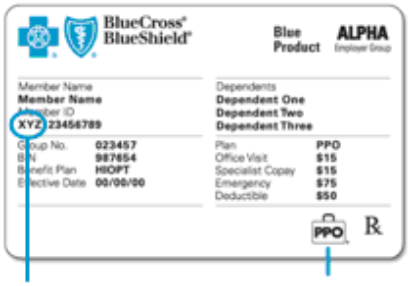
2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

Suitcase logos

BlueCard Member ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The **PPO in a suitcase logo** indicates that the member is enrolled in either a PPO product or an Exclusive Provider Organization (EPO) product. In either case, you will be reimbursed according to Highmark's PPO provider contract.

Note: EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.



The 3-character prefix.

The "PPO in a suitcase" logo may appear in the lower right corner.

One of the key elements of health care reform under the Affordable Care Act (ACA) is the public "exchange" — officially known as the Health Insurance Marketplace. The **PPOB in a suitcase logo** on an ID card indicates that the member has a Blue Plan PPO or EPO product from the exchange. These members have access to a Blue System PPO network referred to as "BlueCard PPO Basic."

Many Blue Plans have created a new BlueCard PPO Basic network; however, Highmark will utilize the same networks as we do for BlueCard PPO (*see Page 3 of this unit*). You will be reimbursed for covered services in accordance with your PPO contract with Highmark.

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2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

Suitcase Logos (continued)

The **empty suitcase logo** indicates that the member is enrolled in one of the following products: traditional, Health Maintenance Organization (HMO), or Point of Service (POS). For members with these products, you will be reimbursed according to Highmark's traditional participating provider contract.

Blue Plan ID cards without suitcase logos

Some Blue Plan ID cards do not have a suitcase logo. Those are the ID cards for Medicaid; State Children's Health Insurance Programs (SCHIP) if administered as part of a state's Medicaid program; and Medicare complementary and supplemental products, also known as Medigap.

Government determined reimbursement levels apply to these products. While Highmark routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic Medicare crossover process.

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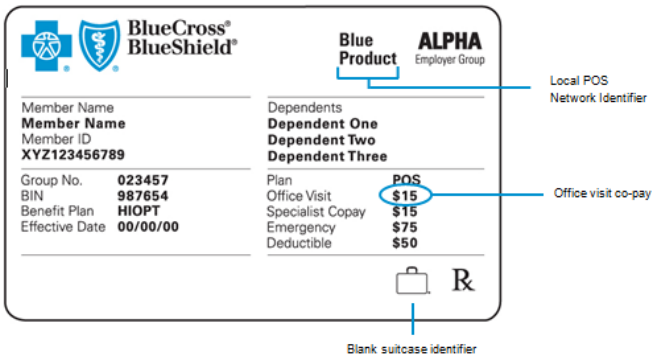
2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

BlueCard Managed Care/POS Program members

The BlueCard Managed Care/POS Program is for members who reside outside their Blue Plan's service area. Unlike in the BlueCard PPO Program, the BlueCard Managed Care/POS members are enrolled in a Highmark network and have a primary care physician (PCP).

You can recognize BlueCard Managed Care/POS members who are enrolled in a Highmark network through the Member ID card as you do for all other BlueCard members. The ID cards will include:

- The 3-character prefix at the beginning of the member's ID number
- A local network identifier
- The blank suitcase logo



2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS

Background

Medicaid is a government program that provides free or low-cost health care to an eligible population. States design their own Medicaid programs within federal guidelines – eligible populations, cost-sharing, benefits, and other rules vary by state. State Medicaid agencies contract with health insurers, including Blue Cross and Blue Shield (BCBS) Plans, as Managed Care Organizations (MCOs) to administer comprehensive Medicaid benefits.

Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out of state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires authorization. Reimbursement for covered services is limited to the Medicaid allowed amount established in the member's home state.

Blue Plan Medicaid ID cards

Members enrolled in BCBS Medicaid plans are issued ID cards from the home plan where they reside, and are usually provided with state-issued Medicaid ID cards. It is important to note that:

- Blue Plan Medicaid ID cards do not always indicate that a member has a Medicaid product.
- Blue Plan Medicaid ID cards **do not have the suitcase logo**.
- The back of the Blue Plan Medicaid ID card must contain a disclaimer indicating limited out-of-area benefits.

Providers should submit an eligibility inquiry if the ID card has no suitcase logo and has a disclaimer with benefit limitations.

Obtaining eligibility & benefits and prior authorization

You can obtain eligibility and benefit information for out-of-area BCBS Medicaid members using the same tools as you would for other out-of-area Blue Plan members:

- Submit an eligibility inquiry using the NaviNet® BlueExchange® function;
- Submit a HIPAA 270/271 electronic eligibility inquiry; or
- Call the BlueCard Eligibility line at **1-800-676-BLUE** (2583).

Providers can also request prior authorization for out-of-area Blue Plan Medicaid members using the same tools available for BlueCard:

- BlueExchange;
- BlueCard Eligibility Line at **1-800-676-BLUE** (2583); and
- Electronic Provider Access (EPA) tool for pre-service review, including prior authorization.

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2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS,
Continued

Claim submission and reimbursement

Although BCBS Medicaid claims are processed through the BCBS Inter-Plan system, Medicaid is not officially part of the BlueCard Program since there is no network reciprocity and the locally negotiated rates do not apply to Medicaid claims. However, you still submit out-of-area Blue Plan Medicaid claims to Highmark as you would submit BlueCard claims, and you will receive reimbursement from Highmark. You will be reimbursed according to the member's home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

When you see a Blue Plan Medicaid member from another state, you must accept the Medicaid allowed amount applied in the member's home state even if you do not participate in Medicaid in your own state. Federal regulations limit providers to the Medicaid allowed amount applicable in the member's home state as payment in full. Billing Medicaid members for the amount between the Medicaid allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (**42 CFR 447.15**).

In some circumstances, a state Medicaid program will have an applicable copay, deductible, or coinsurance applied to the member's plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule in the member's home state for that service.

If you provide Medicaid services to a member who is not covered by Medicaid, you will not be reimbursed. In some states, you may bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of services being rendered.

Why blue italics?

Medicaid provider enrollment requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement. To view provider enrollment requirements for BCBS Medicaid states, please see the **Medicaid Provider Enrollment Requirements by State**. (This document is also available in the BlueCard Information Center on the Provider Resource Center; select **INTER-PLAN PROGRAMS** from the main menu.)

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in the state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from Highmark regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.

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2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS,
Continued

Required data elements for Medicaid claims

Medicaid MCOs are required to report specific Medicaid encounter information to their states and may incur a financial penalty if the data is not submitted or incomplete. State Medicaid encounter data reporting requirements vary from state to state. When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides to understand the state's Medicaid requirements for reporting encounter data elements.

The data elements identified below are required on all out-of-area Blue Plan Medicaid claims so that BCBS Medicaid MCOs are able to comply with encounter data reporting applicable to their respective state.

Effective March 2016, applicable Medicaid claims submitted without these data elements **will be denied**:

- National Drug Code (NDC)
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Applicable Medicaid claims submitted without these data elements **may be pended or denied** until the required information is received:

Billing Provider (Second) Address Line	Ordering Provider Identifier and Identification Code Qualifier
Billing Provider Middle Name or Initial	
(Billing) Provider Taxonomy Code	Attending Provider NPI
(Rendering) Provider Taxonomy Code	Operating Physician NPI
(Service) Laboratory or Facility Postal Zone or ZIP Code	Claim or Line Note Text
	Certification Condition Applies Indicator and Condition Indicator (Early and Periodic Screening, Diagnosis and Treatment (EPSDT))
(Ambulance) Transport Distance	
(Service) Laboratory Facility Name	
(Service) Laboratory or Facility State or Province Code	Service Facility Name and Location Information
Value Code Amount	Ambulance Transport Information
Value Code	Patient Weight
Condition Code	Ambulance Transport Reason Code
Occurrence Codes and Date	Round Trip Purpose Description
Occurrence Span Codes and Dates	Stretcher Purpose Description
Referring Provider Identifier and Identification Code Qualifier	

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2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS,
Continued

IMPORTANT: NDC reporting requirements

National Drug Codes (NDC s) are required on **all** applicable out-of-area Blue Plan Medicaid claims, **including inpatient, outpatient, and professional**; claims submitted without applicable NDCs reported will be denied.

837 Reference	837 Professional Data Element Reference	837 Institutional Data Element Reference	Professional Paper Claim Item Reference (CMS1500)	Institutional Paper Claim Form Locator (UB04)
National Drug Code	Loop 2410 LIN03	Loop 2410 LIN03	Item Number 24 Shaded Portion	Form Locator 43

CONVERTING NDCS FROM 10-DIGITS TO 11-DIGITS

Many NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10-digit to an 11-digit format requires a strategically placed zero, dependent upon the 10-digit format.

The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted additional "0" is in a **bold font and underlined** in the following example. Note that hyphens indicated below are used solely to illustrate the various formatting examples for NDCs. **Do not use hyphens when entering the actual data in your paper claim form.**

CONVERTING NDCs FROM 10-DIGITS TO 11-DIGITS					
10-Digit Format on Package	**10-Digit Format Example**	**11-Digit Format**	**11-Digit Format Example**	**Actual 10-Digit NDC Example**	**11-Digit Conversion of Example**
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7597-01 Zyprexa® 10mg Vial	**0**0002759701
5-3-2	99999-999-99	5-4-2	99999-**0**999-99	50242-040-62 Xolair® 150mg vial	50242**0**04062
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	60575-4112-1 Synagis® 50mg vial	6057541120**1**

2.6 INTERNATIONAL BLUE PLANS

Overview

The Blue Cross and Blue Shield Association licenses Blue Plans outside of the United States. International Licensees currently include the following:

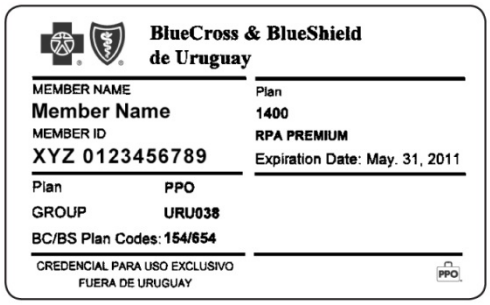
- Blue Cross Blue Shield (BCBS) of U.S. Virgin Islands
- BlueCross & BlueShield of Uruguay
- Blue Cross and Blue Shield of Panama
- Blue Cross Blue Shield of Costa Rica

If in doubt, always check with Highmark as the list of International Licensees may change.

International Blue Plan ID cards

The ID cards from International Licensees will also contain 3-character prefixes and may or may not have a benefit product logo. Please treat these members the same as domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance, and copayment). Submit all claims for these international members to Highmark.

Front of card:



Back of card:

Canadian Association of Blue Cross Plans are separate and distinct

The Canadian Association of Blue Cross Plans and its member Plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Canadian plans for servicing their members. Instructions may be provided on their ID cards.

The Blue Cross Plans in Canada are:

- Alberta Blue Cross
- Manitoba Blue Cross
- Medavie Blue Cross
- Ontario Blue Cross
- Quebec Blue Cross
- Saskatchewan Blue Cross
- Pacific Blue Cross

2.6 GEOBLUE TRAVEL INSURANCE

Overview

GeoBlue[SM] health plans help travelers and expatriates get high quality, safe, and convenient care around the world and are offered in cooperation with many Blue Cross and Blue Shield companies, including Highmark. Through innovative product offerings, including concierge-level service and unsurpassed mobile technology, members who are living or working abroad can find carefully selected doctors and hospitals in more than 180 countries.

These plans provide medical coverage outside the United States for ongoing conditions, preventive health care, or an unexpected medical crisis. GeoBlue enables participating Blue Plans to provide their clients traveling the world with the care they need, when and where they need it, from trusted doctors and hospitals.

GeoBlue is the trade name for the international health insurance programs of Worldwide Insurance Services, an independent licensee of the Blue Cross Blue Shield Association.

2.6 LIMITED BENEFIT PRODUCTS

Overview

Verifying Blue Plan patients' benefits and eligibility is now more important than ever since new products and benefit types have entered the market. In addition to patients who have traditional Blue PPO, HMO, POS, or other coverage with typically high lifetime coverage limits (i.e., $1million or more), you may now see patients whose annual benefits are limited to $50,000 or less.

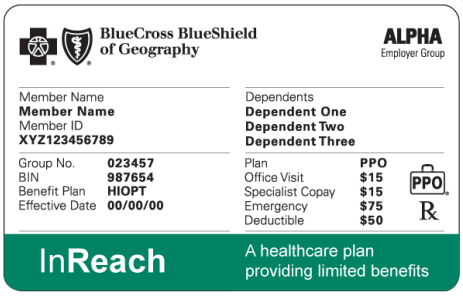
Currently, Highmark does not offer the limited benefit plans described here to our members; however, you may see patients with these limited benefit plans who are covered by another Blue Plan.

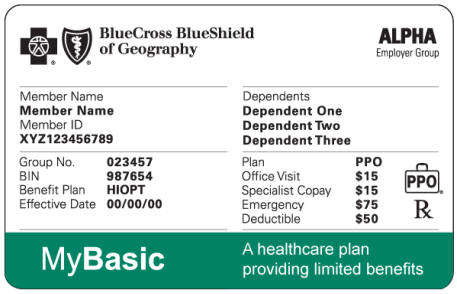
How to recognize members with limited benefits products

Patients with Blue limited benefits coverage carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as **InReach** or **MyBasic;**
- A **green strip** at the bottom of the card;
- A statement either on the front or back of the ID card stating that this is a limited benefit product;
- A **black cross and/or shield** to help differentiate it from other identification cards.

These Blue limited benefits ID cards may look like this:





Verify eligibility and benefits

In addition to obtaining a copy of the patient's ID card, and regardless of the benefit product type, we recommend that you verify the patient's eligibility and benefits. You may do so electronically or you may call the **1-800-676-BLUE** Eligibility Line for out-of-area members.

Both electronically and via telephone, you will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member. If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

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2.6 LIMITED BENEFIT PRODUCTS, Continued

If benefits are exhausted before the end of treatment	Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatments are member liability. We recommend you inform the patient of any potential liability they might have as soon as possible.

2.6 REFERENCED BASED BENEFITS

Overview

Some Blue Plans offer Reference Based Benefits to self-funded group accounts that limit certain (or specific) benefits to a dollar amount that incents members to actively shop for health care for those services.

The goal of Reference Based Benefits is to engage members in their health choices by giving them an incentive to shop for cost-effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated "Reference Cost" ceiling for a single episode of service.

Due to the possibility of increased member cost-sharing, Referenced Based Benefits will incent members to use Plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost-effective providers and/or facilities that charge at or below the reference cost ceiling.

Reference cost

The Blue Plan will pay up to a predetermined amount, called a "Reference Cost," for specific procedures. If the allowed amount exceeds the reference cost, the excess amount becomes the member's responsibility.

The Blue Cross Blue Shield Association (BCBSA) calculates reference costs on a state by state basis with each state representing a "cost region" with its own reference costs. The reference costs are established in a cost region based on claims data provided by the Blue Plan(s) in that region. Reference costs are updated on an annual basis.

Applicable services

The Blue Plan and the employer group collaborate to define the services for which Referenced Based Benefits will apply. Services could include inpatient services, outpatient procedures, and diagnostic services; and services may vary by employer group with coverage under the same Blue Plan. Reference Based Benefits are not applicable to any service that is urgent or emergent.

Verifying coverage

When you submit an electronic eligibility and benefits inquiry prior to performing services, you will be notified if a member is covered under Reference Based Benefits.

Additionally, you may call the BlueCard Eligibility phone number to verify if a member is covered under Referenced Based Benefits:
1-800-676-BLUE (1-800-676-2583)

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2.6 REFERENCED BASED BENEFITS, Continued

Claims, payment, and member responsibility

Reference Based Benefits *do not alter the Highmark fee schedule*. Providers *are paid the applicable fee schedule allowance on all services where Reference Based Benefits apply.*

Why blue italics?

When Reference Based Benefits are applied and the cost of the services rendered is less than the cost ceiling, then Highmark will pay eligible benefits as it has in the past. The member continues to pay their standard cost-sharing amounts in the forms of coinsurance, copay, or deductible as normal.

If the cost of the services rendered exceeds the reference cost ceiling, then Highmark will pay benefits up to that reference cost ceiling. The member continues to pay their standard cost-sharing amounts in the forms of coinsurance, copay, or deductible, as well as any amount above the reference cost ceiling up to the contractual amount.

Example 1: If a member has a reference cost of $500 for an MRI and the allowable amount is $700, then Highmark will pay up to the $500 for the procedure and the member is responsible for the $200.

Example 2: If a member has a reference cost ceiling of $600 for a CT scan and the allowable amount is $400, then Highmark will pay up to the $400 for the procedure.

Consumer transparency tools

Since members are subject to any charges above the Reference Cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost. Also, you can direct members to view their Blue Plan's transparency tools to learn more about the cost established for an episode of care.

The National Consumer Cost Tool (NCCT) is a national effort by Blue Cross and/or Blue Shield Plans across the country to assist members in navigating the health care delivery system. A national database houses pre-calculated cost estimates submitted by Blue Plans, which allows members to view the total cost of specific medical procedures and common office visits for providers across the country.

Note: Highmark members have access to this information through the Care Cost Estimator which is available to them by logging into their account on Highmark's websites.

Questions?

If you have any questions regarding Reference Based Benefits, please contact the Highmark Provider Service Center.

Quick Reference

2.6 CONSUMER DIRECTED HEALTHCARE AND HEALTH CARE DEBIT CARDS

Overview

Consumer Directed Healthcare (CDHC) is a broad term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information, and financial incentives.

Health care debit cards

Members who have CDHC plans often have health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Account (HRA), Health Savings Account (HSA), or Flexible Spending Account (FSA). All three are types of tax-favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "stand-alone" debit cards to cover out-of-pocket costs while others also serve as a Member ID card with the member's ID number. These debit cards can help you simplify your administration process and can potentially help:

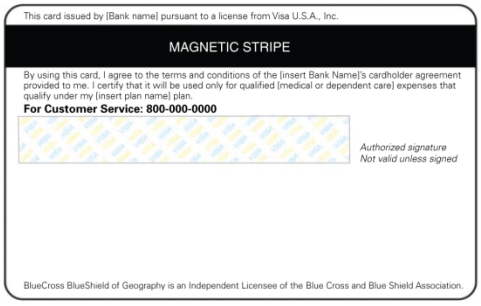
- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks along with the logo from a major debit card such as MasterCard® or Visa.®

Example: Stand-alone health care debit card

Front of card:

Back of card:



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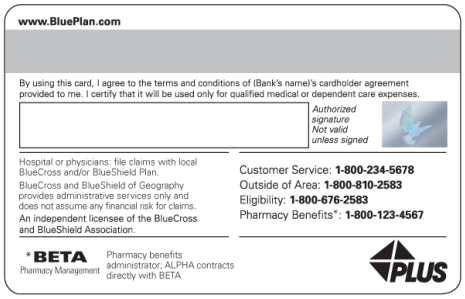
2.6 CONSUMER DIRECTED HEALTHCARE AND HEALTH CARE DEBIT CARDS, Continued

Example: Combined health care debit card and Member ID card

Front of card:

Back of card:



Health care debit card details

The health care debit card includes a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With health care debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA, or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards because of the payment capabilities.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

Helpful tips

The following tips will be helpful when you are presented with a health care debit card:

- Carefully determine the member's financial responsibility before processing payment. You can access the member's benefits and accumulated deductible by using online electronic capabilities or by contacting the BlueCard Eligibility Line at **1-800-676-BLUE** (2583).
- You may use the debit card for member responsibility (i.e., copay) for medical services provided in your office. Please do not use the card to process full payment upfront.

Continued on next page

2.6 CONSUMER DIRECTED HEALTHCARE AND HEALTH CARE DEBIT CARDS, Continued

Helpful Tips (continued)

- You may choose to forego using the debit card on the date of service and wait for the claims to be processed by Highmark to determine the member's responsibility.
- All services, regardless of whether or not you have collected the member responsibility at the time of service, must be billed to Highmark for proper benefit determination and to update the member's claim history.

Questions?

If you have any questions about the member's benefits, check eligibility and benefits electronically or by calling **1-800-676-BLUE** (2583).

For questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

2.6 HEALTH INSURANCE MARKETPLACES

Overview

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (or "Exchanges") in each state where individuals and small businesses can purchase qualified coverage. These exchanges are websites through which eligible consumers may purchase insurance.

The Marketplaces are intended to create a more organized and competitive marketplace for health insurance by offering members a choice of health insurance plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. The Marketplaces will enhance competition in the health insurance market, improve choice of affordable health insurance, and give individuals and small businesses purchasing power comparable to that of large businesses.

The Marketplaces offer consumers a variety of health insurance plans. Product and Plan information, such as covered services and cost sharing (i.e., deductibles, coinsurance, copayments, and out-of-pocket limits) are organized in a manner that makes comparisons across health insurance plans easier for consumers.

In conjunction with offering a choice of health insurance plans, the Marketplace is intended to provide consumers with transparent information about health insurance plan provisions such as premium costs and covered benefits as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

What Is My Service Area?

Marketplace options

Each state was given the option to set up its own "state-based" Marketplace approved by the Department of Health and Human Services (HHS) for marketing products to individual consumers and small employers. If the state did not set up a state-run marketplace, HHS has established either a federally-facilitated Marketplace or a Federal partnership Marketplace in the state.

Blue Plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and employer-sponsored health insurance products.

Pennsylvania has a Federally Facilitated Exchange (FFE) marketplace. The federal government, mainly through the Department of Health and Human Services, will operate nearly all of the functions. It will verify eligibility for buying coverage, determine subsidies, and oversee enrollment, plan management, consumer assistance, and financial management.

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2.6 HEALTH INSURANCE MARKETPLACES, Continued

Marketplace options (continued)

Delaware and West Virginia are two of the seven states that formed state-federal partnerships with the states operating the plan management and consumer assistance functions of the Marketplace.

What Is My Service Area?

OPM Multi-State Plan Program

Under the Affordable Care Act (ACA) of 2010, the Office of Personnel Management (OPM) was required to offer OPM-sponsored products on the Marketplaces beginning in 2014. For a coverage effective date of January 1, 2015, Blue Cross and Blue Shield Plans participated in this program by offering these Multi-State Plans on Marketplaces in 33 states and the District of Columbia, including Highmark in Pennsylvania, Delaware, and West Virginia. The ACA requires these products to be offered across all states and the District of Columbia by 2017.

These products are similar to the other Qualified Health Plan products offered on the Marketplaces. Generally, all of the same requirements that apply to other State Marketplace products also apply to these Multi-State Plan products.

Exchange Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally-mandated individual grace period, providers may receive a notification from Highmark indicating that the member is in the grace period.

Claims and utilization review

Providers should follow current practices with Highmark for claims processing and handling of Marketplace claims. You can make claim status inquiries through Highmark or by submitting an electronic inquiry to Highmark.

If authorization/precertification is needed, you should follow the same protocol as you do for any other BlueCard members.

2.6 BLUE EXCHANGE FOR INQUIRIES AND AUTHORIZATIONS

Overview

BlueExchange was developed by the Blue Cross Blue Shield Association as a gateway for routing inquiries about out-of-area members between providers and the member's Blue Plan. BlueExchange transactions submitted through Highmark are routed to the member's Blue Plan based on the prefix.

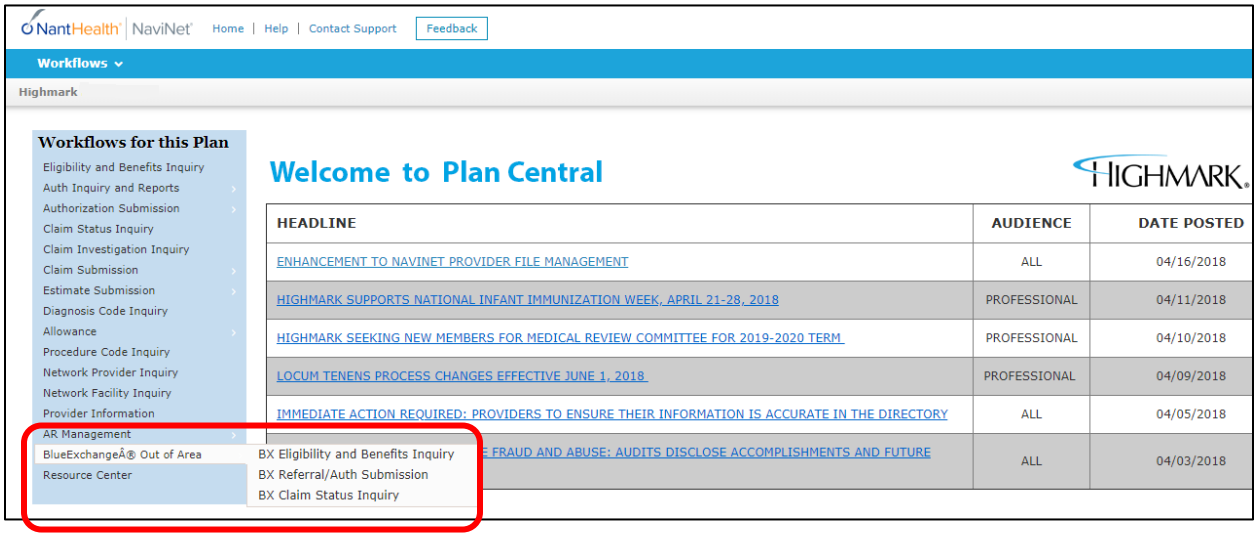
BlueExchange simplifies your exchanges for out-of-area members using HIPAA-compliant transactions. There are three primary types of transactions that can be routed via BlueExchange:

- Eligibility and Benefits Inquiry and Response;
- Claim Status Inquiry and Response; and
- Referral/Authorization Requests.

Accessing BlueExchange via NaviNet

Highmark provides you with convenient, easy-to-use access to BlueExchange via NaviNet®. Each of these transactions can be initiated through Highmark's BlueExchange portal within NaviNet.

The **BlueExchange (Out-of-Area)** option in the Plan Central menu allows you to choose from the three transactions.



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2.6 BLUE EXCHANGE FOR INQUIRIES AND AUTHORIZATIONS,
Continued

NaviNet User Guides

NaviNet User Guides can provide helpful tips on using the BlueExchange transactions. To access, click on **Help** in the navigation panel at the top of the NaviNet screen to open the NaviNet Support window. Select the applicable Highmark plan for your service area to access all available User Guides.

Electronic transactions routed via BlueExchange

If your office has the capability, the following transactions can be submitted to Highmark for out-of-area members via your practice management software and routed via BlueExchange:

- 270 for Eligibility and Benefits
- 276 for Claim Status
- 278 for Utilization Review

Highmark will route both the inquiry and response transactions between you and the member's Blue Plan via BlueExchange.

2.6 BLUECARD ELIGIBILITY AND BENEFITS VERIFICATION

Overview

As a Highmark participating provider, you have three options for verifying eligibility for members of other Blue Plans:

- Submit an electronic HIPAA 270 transaction to Highmark;
- Initiate a BlueExchange® inquiry within NaviNet®; or
- Call the BlueCard® Eligibility line at **1-800-676-BLUE** (2583).

Electronic transactions preferred

Electronic transactions and online communications have become integral to health care, and they are the preferred method of interaction between providers and Highmark. Today's technology can help you simplify business operations, cut costs, and increase efficiency in your office.

Electronic options for verifying eligibility and benefits for out-of-area Blue Plan members provide a very quick turnaround -- with responses in seconds. You can use the following electronic options for verifying eligibility and benefits for an out-of-area member:

- **Submit a HIPAA 270 Eligibility Inquiry transaction to Highmark:** Highmark will route both the inquiry and the 271 response transactions between you and the member's Blue Plan via BlueExchange; or
- **Initiate a BlueExchange inquiry from within NaviNet:** The *BlueExchange Eligibility and Benefits Inquiry* transaction allows users to access up-to-date eligibility and benefits information for out-of-area members.

BlueCard Eligbility phone line

For those offices that are not electronically-enabled, the Blue Cross Blue Shield Association provides a toll-free phone line for eligibility and benefit inquiries for BlueCard members. Contact BlueCard Eligibility at **1-800-676-BLUE** (2583).

- English and Spanish speaking phone operators are available to assist you.
- Blue Plans are located throughout the country and may operate on a different time schedule than Highmark; you may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
- The BlueCard Eligibility Line is for eligibility, benefit, and precertification and referral authorization inquiries only; it should not be used for claim status. Direct all claim inquiries to Highmark.

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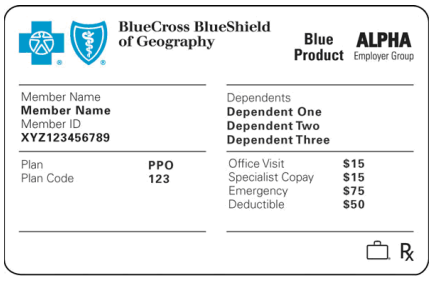
2.6 BLUECARD ELIGIBILITY AND BENEFITS VERIFICATION, Continued

Electronic health ID cards

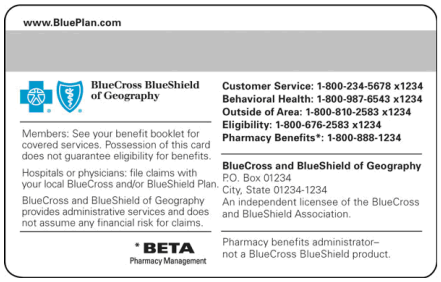
Some Blue Cross Blue Shield Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.

- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
- A Blue Plan electronic health ID card has a magnetic stripe on the back of the card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the 3-track magnetic stripe.
- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth, and Plan ID.
- Providers will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 and 2 of the magnetic stripe; tracks 1 and 2 are proprietary to the financial industry).
- The Plan ID data element identifies the health plan that issued the ID card. Plan ID will help providers facilitate health transactions among various payers in the marketplace.
- An example of an electronic ID card:

Front of card



Back of card



2.6 UTILIZATION REVIEW

Introduction

Traditionally, many Blue Plan members have been held responsible for obtaining pre-service review from their Home Plan when receiving inpatient and outpatient care in another Blue Plan's service area. If authorization is not obtained, the member could be subject to financial penalties.

Pre-service review defined

Pre-service review is defined as the process of obtaining authorization for medical treatment prior to select procedures and services. The process is commonly referred to as precertification, preauthorization, notification, and/or pre-admission.

Inpatient services

Effective July 1, 2014, under a new Blue Cross Blue Shield Association (BCBSA) initiative, all Blue Plans must require participating providers to obtain pre-service review for inpatient facility services for out-of-area members. In addition, members are held harmless when pre-service review is required and not obtained by the provider for inpatient facility services (unless an account receives an approved exception).

These requirements apply to all fully-insured health benefit plans. However, if a self-funded employer group wishes to keep member precertification penalties in place, a formal exception can be filed with the BCBSA. If an account receives an approved exception, a member penalty could apply if pre-service review is not obtained for inpatient services.

Highmark provider contracts require participating providers to obtain pre-service review for inpatient facility services for our members and also out-of-area BlueCard® members. Highmark participating providers are also required to hold members harmless if the member's plan requires pre-service review and the provider did not attempt to acquire an authorization.

This initiative also requires Blue Plan participating providers to keep the Home Plan informed of changes in a member's condition. Providers must notify the member's Home Plan within forty-eight (48) hours when a change to the original pre-service review occurs, and within seventy-two (72) hours for emergency and/or urgent admissions.

Note: This policy does not affect medical necessity. Services must still be medically necessary, appropriate, and a covered benefit. If, prior to service or care, the provider requests authorization and it is denied, a Highmark participating provider can bill the member if the member was informed of the denial and agreed in writing to be responsible for payment for the service or care.

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2.6 UTILIZATION REVIEW, Continued

Outpatient services

Although providers are responsible for obtaining pre-service review for inpatient facility services, your out-of-area Blue Plan patients are responsible for obtaining precertification/preauthorization from their Blue Plan when required for outpatient services. However, you may contact the member's Blue Plan for authorization on behalf of the member.

Outpatient services provided by out-of-area Blue Plan providers

Effective November 1, 2020, Highmark is expanding our prior authorization requirements for outpatient services to include those services provided by out-of-area providers participating with their local Blue Plan. This will assure that the care our members receive while living and traveling outside of the Highmark service areas is medically necessary and managed consistently as it is throughout our service areas.

Out-of-area Blue Plan providers will be required to contact Highmark for prior authorization for services on our List of Procedures/DME Requiring Authorization. Highmark is enabling our NaviNet® portal functionality to accept authorization requests for outpatient services from out-of-area Blue Plan providers when submitted via their local portals.

Claims for services on the prior authorization list received without authorization will deny and a request for medical records will be sent to the provider's local Blue Plan.

Medical Policy and Precertification/ Preauthorization Router for Out-of-Area Members

Highmark provides you with a tool to access Medical Policy and general precertification/preauthorization information for out-of-area members from other Blue Plans. All you need is the out-of-area member's prefix to find the information for the home plan.

On the Provider Resource Center, select **INTER-PLAN PROGRAMS** from the main menu, and then choose **Medical Policy and Pre-Certification/Pre-Authorization Router for Out-of-Area Members**. This link is also available in the **BlueCard Information Center**.

Note: This feature is not available for members in the Federal Employee Program (FEP) or in a Medicare Advantage Program.

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2.6 UTILIZATION REVIEW, Continued

How to obtain authorization

The following options are available to you for obtaining pre-service review/pre-authorization for out-of-area BlueCard members:

- **Submit an electronic HIPAA 278 transaction (Referral/Authorization) to Highmark** via your practice management software. Highmark will route both the inquiry and response transactions between you and the member's Blue Plan via BlueExchange.
- **Initiate a BlueExchange authorization request submission via NaviNet**. Select the **BlueExchange (Out-of-Area)** option from NaviNet's Plan Central menu, and then click on **BX Referral/Auth Submission** on the fly-out menu.
- **Use the new Electronic Provider Access (EPA) function available in NaviNet**. Select **Authorization Submission** from NaviNet's Plan Central menu, and then click on **PreService Review for Out of Area Members** on the fly-out menu. This option will take you directly to the member's Home Plan provider portal to conduct electronic pre-service review. **Note:** This function is not yet available for access to all Blue Plans. Please see the next section of this unit for more information.
- **Call BlueCard Eligibility at 1-800-676-BLUE** (2583) and ask to be transferred to the utilization review area. Your call will be routed directly to the area that handles precertification/preauthorization at the member's Home Plan.

When obtaining precertification/preauthorization, please provide as much information as possible to minimize potential claims issues. Providers are encouraged to follow up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

The member's Blue Plan may contact you directly related to clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

2.6 ELECTRONIC PROVIDER ACCESS (EPA)

Overview

On January 1, 2014, the Blue Cross and Blue Shield Plans launched a new tool that gives providers the ability to access an out-of-area member's Blue Plan (Home Plan) provider portal to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, precertification, preauthorization, and prior approval, amongst other pre-claim processes.

Electronic Provider Access (EPA) enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The ability to access the Home Plan's portal for pre-service review will result in a more efficient pre-service review process, reduced administrative costs for both the provider and the Blue Plan, and improved provider and member satisfaction.

Implementation schedule

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans are fully implemented and have electronic pre-service review for many services, while others have not yet implemented electronic pre-service review capabilities.

Highmark has already implemented EPA and the EPA tool is ready for your use through NaviNet.® To determine if another Blue Plan has already implemented electronic pre-service review, please reference the **Plan Implementation Schedule**. This schedule is also available in the BlueCard Information Center on the Provider Resource Center (in Pennsylvania and Delaware).

Note: The schedule reflects anticipated EPA implementation by Home Plan, indicating the date which electronic pre-service review will be available for inpatient, high-tech radiology, and other services. Providers should keep in mind that, although this schedule reflects planned implementation to date, some Plans may experience delays.

Determine if precertification is required

You can first check whether precertification is required by the member's Home Plan by either:

- Sending a service-specific request through NaviNet's *BlueExchange*®; or
- Accessing the Home Plan's precertification requirements pages by using the Medical Policy Router available on the Provider Resource Center. (Select **INTER-PLAN PROGRAMS** from the main menu, and then select the **Medical Policy and Pre-certification/Pre-authorization Information for Out-of-Area Members** link.)

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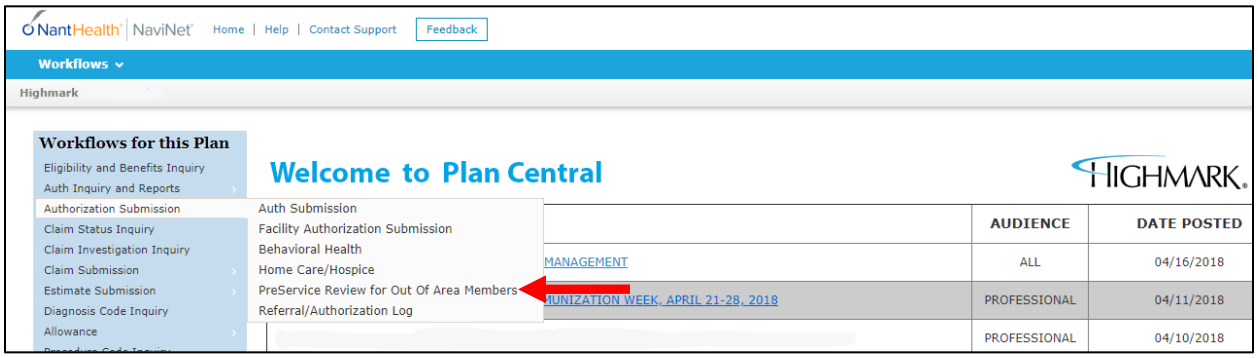
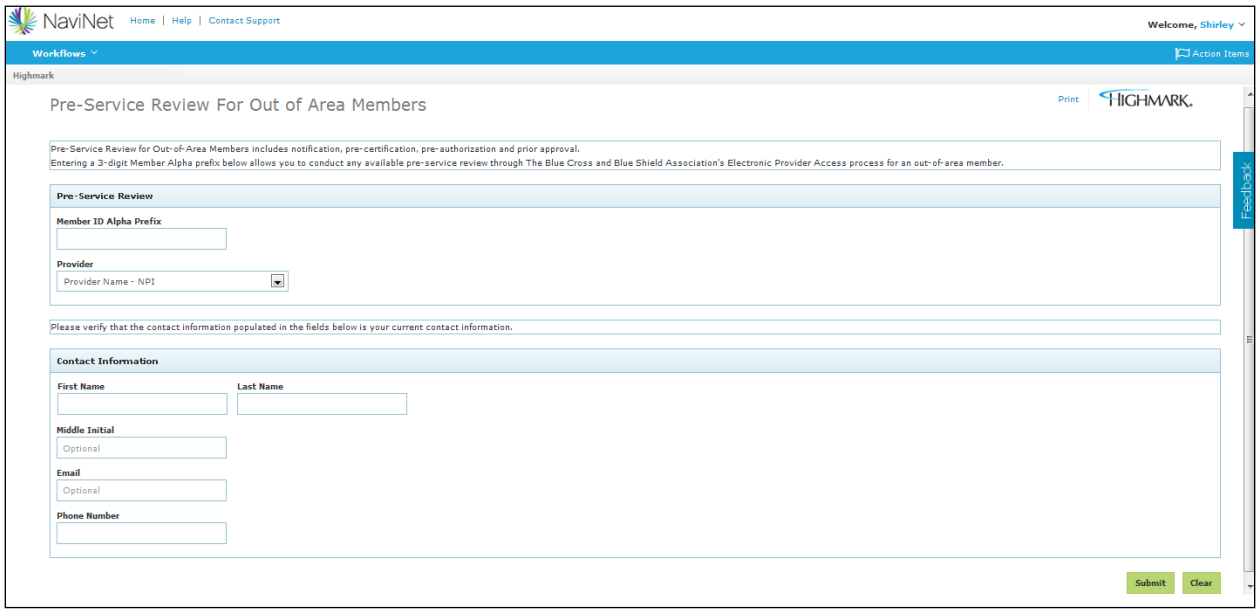
2.6 ELECTRONIC PROVIDER ACCESS (EPA), Continued

Using the EPA tool

As a Highmark provider, you will initiate this process by logging into NaviNet as you normally would for other purposes. From **Authorization Submission** in NaviNet's main menu, select **Pre-Service Review for Out of Area Members** from the fly-out menu.



You will be asked to enter the prefix from the member's ID card. (The prefix is the first three characters of the Member ID.)



After entering the prefix, you will be automatically routed to the member's Home Plan EPA landing page. This page will welcome you to the member's Home Plan portal and indicate that you have left Highmark's portal. The landing page will allow you to connect to the available electronic pre-service review processes.

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2.6 ELECTRONIC PROVIDER ACCESS (EPA), Continued

Using the EPA tool (continued)

Because the screens and functionality of Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page will also include instructions for conducting pre-service review for services where the electronic function is not available.

Note: Electronic Provider Access (EPA) for pre-service review does not support the Federal Employee Program (FEP). Please contact Highmark for FEP members, whose identification numbers begin with an "R."

FOR MORE INFORMATION

Additional resources are available in the **BlueCard Information Center** on the Provider Resource Centers in Pennsylvania and Delaware, including the following:

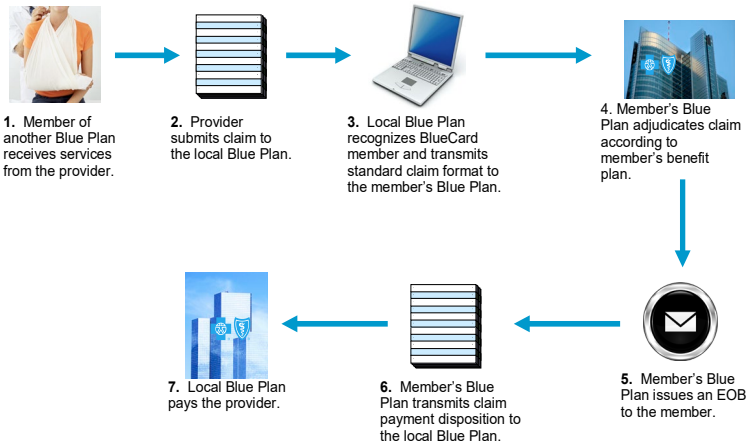
- **EPA Tip Sheet**
- **Blue Plan Implementation Schedule**

What Is My Service Area?

2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY

How claims flow through BlueCard®

The diagram below illustrates how claims flow through BlueCard:



Submit BlueCard claims to Highmark

You should **always submit out-of area Blue Plan claims to Highmark** using the applicable NAIC code as the payer code in the 837 Health Care Claim transaction. Highmark will work with the member's Blue Plan to process the claim. The member's Blue Plan will send an Explanation of Benefits (EOB) to the member.

Highmark will send you an explanation of payment or remittance advice. We will also issue the payment to you under the terms of our contract with you and based on the member's benefits and coverage.

FOR MORE INFORMATION

Please see the **NAIC Codes** section of this unit for complete information on all Highmark NAIC payer codes.

Helpful tips

Electronic claims submission is a valuable method of streamlining claim submission and processing, and results in faster payment. Following these helpful tips will improve your claim experience:

- Ask members for their current Member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including the prefix) and avoid unnecessary claims payment delays.
- Consider electronic inquiries if you wish to inquire about precertification requirements before the service is provided, or call **1-800-676-BLUE** (2583) and ask to be connected with the utilization review area.

Continued on next page

2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

Helpful Tips (continued)

- Check eligibility and benefits to verify the member's cost-sharing amount before processing payment.
- Indicate on the claim any payment you collected from the patient.
  - On the 837I and the 837P electronic claim submission, use the Patient Amount Paid Segment (AMT01=F5 patient paid amount).
  - On the 1500 Claim Form, report the amount paid in locator Box 29. This is the total of patient and other payer(s) prior paid, not just patient prior paid.
  - On the UB-04, report this information in locator Box 54.
- Submit all Blue Plan claims to your local Highmark plan. Be sure to include the member's complete identification number when you submit the claim. This includes the 3-character prefix. Submit claims with valid prefixes only. **Claims with incorrect or missing prefixes and member identification numbers cannot be processed.**
- Check claim status through NaviNet's Claim Status Inquiry or by submitting an electronic HIPAA 276 transaction (Claim Status Request) to Highmark. All claim inquiries should be directed to Highmark and not the member's Plan.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and causes confusion for the member receiving multiple EOBs for the same services.

International claims

The claim submission process for international Blue Plan members is the same as for domestic Blue Plan members. You should submit the claims directly to Highmark.

Note: Please see the section on *How to Identify International Members* in this unit for information on servicing members of the Canadian Blue Cross Plans.

Coding

Code claims as you would for Highmark claims.

Claim status inquiry

Highmark is your single point of contact for all claim inquiries.

- NaviNet's *Claim Status Inquiry,* used to view local claims, can also be used to find the latest status on out-of-area claims. To view out-of-area claims electronically, you must include the prefix when entering the member's identification number.
- BlueExchange® is another option Highmark offers through NaviNet for obtaining BlueCard claim status. The claim status inquiry option in BlueExchange even allows you to search for the status of out-of-area Medicare cross-over claims or those filed directly to the member's Home Plan.

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2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

Adjustments

Contact Highmark if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different. To initiate adjustments:

- Search for the claim in question via the *Claim Status Inquiry* within NaviNet, and then initiate an adjustment request via the *Claims Investigation Inquiry*.
- Providers who are not NaviNet-enabled should submit adjustments electronically via the HIPAA 837 transaction if your office system is capable.

Provider appeals

Provider appeals are handled through Highmark. We will coordinate the appeal process with the member's Blue Plan if needed.

However, if you are appealing on behalf of the member, direct your inquiry to the member's Blue Plan. To inquire about the Plan's process to initiate an appeal on behalf of the member, please call the Customer Service phone number on the member's identification card.

If claim payment is not received

If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs).

Claim processing times can differ at the various Blue Plans. If you do not receive your payment or a response regarding your payment within thirty (30) days, please visit NaviNet, submit a HIPAA 276 (claim status request), or call Highmark's Provider Service Center to check the status of your claim.

In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, Highmark may either ask you for the information or give the member's Blue Plan permission to contact you directly.

Coordination of benefits

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more than one health plan, and:

- **Highmark or any other Blue Plan is the primary payer,** submit the other carrier's name and address with the claim to Highmark. If you do not include the COB information with the claim, the member's Blue Plan will

Continued on next page

2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

Coordination of benefits (continued)

have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment which will increase your volume of bookkeeping.

- **a non-Blue health plan is primary and Highmark or any other Blue Plan is secondary,** submit the claim to Highmark only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment which will increase your volume of bookkeeping.

Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Highmark remittance advice as patient liability may be different from the actual amount the patient owes you due to a combination of two or more insurance payments.

What Is My Service Area?

Coordination of Benefits Questionnaire available online

Highmark depends on help from the member and/or provider to obtain accurate, up-to-date information about Coordination of Benefits (COB). The provider's assistance with this process will eliminate the need to gather the information later, thereby reducing potential claim processing delays.

If you would like to assist, the **Coordination of Benefits Questionnaire for BlueCard Members** is available to you here and also on the Provider Resource Centers in Pennsylvania. To access from the Pennsylvania Provider Resource centers, select **INTER-PLAN PROGRAMS** from the main menu, and then **BlueCard Information Center**.

If you wish to have the questionnaire completed by the policyholder at the time of service, you can choose to fax the completed form with the policyholder's signature to Highmark. Be sure to use a fax cover sheet that includes contact information for your practice or facility. The toll-free fax number is provided on the instruction sheet attached to the COB form. **This fax number is for provider use only for submission of BlueCard COB Questionnaires. Please do not give this fax number to members.**

Or, you can ask the member to complete the form and then send it to their Home Plan – the Blue Plan through which they are covered – as soon as possible after leaving your office or facility. Members should mail the form to the Blue Plan address listed on the back of their member identification card where they will also find their Home Plan's telephone number if they have questions.

Continued on next page

2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

Calls from BlueCard members

If BlueCard members contact you with questions about claims, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Blue Plan should not contact you directly regarding claims issues. If the member's Plan contacts you and asks you to submit the claim to them, refer them to Highmark.

FOR MORE INFORMATION

For more information:

- Visit the **BlueCard Information Center** on the Provider Resource Center – select **INTER-PLAN PROGRAMS** from the main menu to access.
- Call Highmark Provider Services

Quick Reference

2.6 ITEMIZED BILLS REQUIRED FOR HIGH-DOLLAR HOST CLAIMS

Background

Effective January 1, 2019, the Blue Cross Blue Shield Association (BCBSA) requires Blue Plans serving as the Host Plan for out-of-area Blue Plan members to perform high-dollar prepayment reviews for certain claims and communicate results of these reviews to the members' Home Plans. The review process must be conducted prior to passing the host claim to the Home Plan.

Definitions: Home and Host Plans

The **Home Plan** is the Blue Cross and/or Blue Shield Plan where the insured is enrolled. The **Host Plan** is any other Blue Plan whose contracted providers are providing health care services to a Blue Plan member outside of his or her home plan's service area.

For example, Highmark serves as the Host Plan when an out-of-area Blue Plan member (e.g., has coverage through BlueCross BlueShield of Illinois) seeks services from a Highmark participating provider in our service areas.

Therefore, a **host claim** would be a claim that you submit to Highmark for services you provided to an out-of-area Blue Plan member. Highmark forwards the host claim to the member's Home Plan internally through the BlueCard electronic system, and then the Home Plan adjudicates the claim, sending the information back to Highmark in order for Highmark to reimburse you.

What Is My Service Area?

Requirements for providers

Highmark requires itemized bills for all high-dollar host claims that meet the criteria below and are received by Highmark beginning January 1, 2019, and after. The requirements under this initiative apply regardless of how claims were submitted.

Host claims that meet the following criteria require submission of itemized bills:

- Inpatient acute care;
- Allowance of $250,000 or greater;
- All lines of business, **except** Medicare Supplemental/Medigap and Medicaid; and
- Any pricing methodologies that are price based on charges (e.g., percentage-based).

NOTE: These requirements **do not apply** to the following claims pricing models that do not incorporate individual services or charges due to global pricing methodology:

- Per-diem
- Flat-fee case rate
- DRG (Diagnosis-Related Group) rate

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2.6 ITEMIZED BILLS REQUIRED FOR HIGH-DOLLAR HOST CLAIMS,
Continued

Submitting itemized bills to Highmark

Providers can fax itemized bills to **1-855-329-8191**. Please use your facility's fax cover sheet and include all applicable information on the cover sheet, such as patient account number, claim number, Member ID number with alpha prefix, etc.

IMPORTANT: Please include the following on the cover sheet to assure your faxed information is directed to the appropriate area:

ATTENTION: Payment Integrity, Host High Dollar Review, Kelly Rizor

If you are unable to fax the itemized bill, it can be mailed to:

ATTN: Kelly Rizor, Payment Integrity/ Host High-Dollar Review
Highmark
120 5th Avenue, Suite P3103
Pittsburgh, PA 15222

If itemized bill is not received

If Highmark does not receive an itemized bill **within five (5) days** of receipt of a claim that meets the criteria of a high-dollar host claim, the claim will be rejected with code **E1224**: "In order to process the claim, additional information is required. The claim should be resubmitted with an Itemized Bill for each date of service reported."

After the Itemized Bill is reviewed and there are still discrepancies found, the claim will be rejected with code **E1222**: "Discrepancies were found during the High Dollar Prepayment Review. Please review and resubmit a replacement claim for reconsideration."

2.6 NAIC CODES

Overview

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

NAIC codes are unique identifiers assigned to individual insurance carriers. Accurate reporting of NAIC codes along with associated prefixes and suffixes to identify the appropriate payer and to control routing is critical for electronic claims submitted to Highmark EDI (Electronic Data Interchange).

Claims billed with the incorrect NAIC code will reject on your 277CA report as A3>116, "Claim submitted to the incorrect payer." If this rejection is received, please file your claim electronically to the correct NAIC code. Please refer to the tables below for applicable NAIC codes for your service area.

What Is My Service Area?

Pennsylvania

PENNSYLVANIA		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
54771W	Western Region facility type providers (UB-04/837I)	• All Highmark commercial products; • Medicare Advantage Security Blue HMO and Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
54771C	Central Region facility type providers (UB-04/837I)	• All Highmark commercial products; • Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.

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2.6 NAIC CODES, Continued

What Is My Service Area?

Pennsylvania (continued)

PENNSYLVANIA (cont.)		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
54771	All other provider types (1500/837P)	• All Highmark commercial products; • Medicare Advantage Security Blue HMO (Western Region only) and Medicare Advantage Community Blue HMO, both administered by Highmark Choice Company; and • All BlueCard products and Medicare Advantage claims for any other Blue Plan.
15460	All provider types	• Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes **HRT** and **HRF**). • Medicare Advantage Community Blue Medicare PPO (prefixes **QLS**, **QMV**, **QJS**, **QKS**) and Community Blue Medicare Plus PPO (prefixes **FYO**, **FZO**).

Highmark Delaware

DELAWARE		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
00070	Facility provider types	All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
00570	All other provider types	All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.

Highmark West Virginia

WEST VIRGINIA		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
54828	All provider types	All Highmark West Virginia products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.
15459	All provider types	Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with prefix **HSR**).

2.6 CONTIGUOUS COUNTY CONTRACTING

BCBSA contiguous county rules

A **contiguous area** is generally a border county in another Blue Plan's service area one county over from the Plan's own service area. Per Blue Cross Blue Shield Association (BCBSA) regulations, a Plan ("Licensee") is permitted to use its Brands outside its service area when: "Contracting with health care providers in a contiguous area in order to serve its subscribers residing or working in the Licensee's own service area."

If you are a provider located in a contiguous area, your provider contract with Highmark only applies for services rendered in that contiguous area to members who live or work in the service area.

When contiguous county rules do not apply

The contiguous area contract application limitation **does not apply** to ancillary providers (independent labs, durable/home medical equipment and supplies, and specialty pharmacy) or in overlapping service areas, where multiple Blue Plans share the same service area.

Highmark Blue Shield shares the service area in the 21-county Central Region of Pennsylvania with Capital BlueCross. In the 5-county Eastern Region of Pennsylvania, Highmark Blue Shield is licensed to contract with professional providers, while Independence Blue Cross is also licensed in this service area. In both the Central Region and Eastern Region service areas, overlapping service area claims filing rules apply. You can click on the **What Is My Service Area?** icon to identify the counties within these service areas.

Please refer to the applicable sections in this unit for claim submission guidelines for ancillary claims and for overlapping service areas.

2.6 OVERLAPPING SERVICE AREAS

Introduction

An **overlapping service area** is formed when multiple Blue Plans are licensed by the Blue Cross Blue Shield Association (BCBSA) within the same service area.

Claims filing rules

Submission of claims in overlapping service areas is dependent on what Blue Plan(s) the provider contracts with in that state, the type of contract the provider has (i.e., PPO, Traditional), and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either Blue Plan.
- If you have a PPO contract with one Blue Plan, but a Traditional contract with another Blue Plan, file the out-of-area Blue Plan member's claim by product type. For example, if it is a PPO member, file the claim with the Plan with which you have the PPO contract.
- If you contract with one Plan and not the other, file all claims with your contracted Plan.

Within the 21-county central Pennsylvania and Lehigh Valley area, Highmark Blue Shield markets in the same region as another Blue Plan. If you treat a Highmark Blue Shield member who resides within those 21 counties, you must send your claim to Highmark even if you also contract with the other Blue Plan.

Note: Overlapping service area guidelines do not apply to ancillary claims.

What Is My Service Area?

2.6 ANCILLARY CLAIM FILING RULES

Claim filing rules

Ancillary providers include independent clinical laboratory, durable/home medical equipment and supplies, and specialty pharmacy providers. File claims for these providers as follows:

- **Independent Clinical Laboratory:** To the Blue Plan in whose state the specimen was drawn based on the location of the referring provider.
- **Durable/Home Medical Equipment and Supplies:** To the Blue Plan in whose state the equipment was shipped to or purchased at a retail store.
- **Specialty Pharmacy:** To the Blue Plan in whose state the Ordering Physician is located.

The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.

2.6 MEDICAL RECORDS REQUESTS

Overview

Blue Plans around the country have made improvements to the medical records process to make it more efficient. They are able to send and receive medical records electronically between Blue Plans.

This method significantly reduces the time it takes to transmit supporting documentation for out-of-area claims, reduces the need to request records multiple times, and significantly reduces lost or misrouted records.

Requests for medical records

You may get requests for medical records for out-of-area members under the following circumstances:

- **Preauthorization** -- If you receive requests for medical records from other Blue Plans prior to rendering services (as part of the preauthorization process), you will be instructed to submit the records directly to the member's Home Plan that requested them. **This is the only circumstance where you would not submit medical records to Highmark.**
- **Claim Review and Adjudication –** These requests will come from Highmark in the form of a letter requesting specific medical records and including instructions for submission.

Submitting records to Highmark for claim review

When medical records are needed as part of claim review, Highmark relays that request to you in the form of a letter sent via the postal mail. The request includes the following information about the claim: the patient name, claim number, date and place of service, procedure code, contract/identification number, and provider's charge. The letter will provide a fax number and mailing address to which your office can direct the requested records.

We recommend that, unless the number of pages you must provide is excessive, you return the requested medical record information to our BlueCard Host area via **fax** at **1-866-251-9601**. Faxing is the preferred method of submission as information received via fax is able to be expedited and processed more quickly than records sent via postal mail.

Most often complete medical records are not necessary; therefore, send only the information requested. Return the records as quickly as possible to Highmark and use the request letter as a cover sheet placed in front of any records you return. In this way, the receipt of the records is streamlined; they are received directly by the appropriate department at Highmark and are easily identified, imaged, and routed to the Home Plan through secure software that facilitates the exchange.

Upon receipt of the requested information, the claim will be reviewed and Highmark will notify you of the final determination.

Continued on next page

2.6 MEDICAL RECORDS REQUESTS, Continued

If you receive a remittance advice message about medical records

The medical records you submit may at times cross in the mail with the remittance advice; therefore, a remittance may be received by your office/facility indicating the claim is being denied pending receipt and review of records.

A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Highmark to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.

If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Highmark to determine if the records are needed from your office.

IMPORTANT! Do not send unsolicited records

Please do not proactively send medical records with a claim unless requested. Unsolicited claim attachments may cause claim payment delays.

2.6 BLUECARD QUICK TIPS

Quick tips

The BlueCard® Program provides a valuable service that lets you file all claims for members from other Blue Plans with Highmark.

Here are some key points to remember:

1. Make a copy of the front and back of the member's ID card.
2. Look for the 3-character prefix that precedes the member's identification number on the ID card.
3. Consider electronic means first for eligibility inquiries:
   - Submit a BlueExchange® Inquiry via NaviNet®; or
   - Submit a HIPAA 270 transaction to Highmark.
4. Or, call BlueCard Eligibility **1-800-676-BLUE** (2583) for eligibility inquiries:
   - English and Spanish speaking operators are available;
   - Because of time zone differences, you may sometimes reach a voice response system linked to enrollment and benefits.
5. Submit the claim to Highmark using the appropriate NAIC code.
   - **Pennsylvania:** Western Region Facility – 54771W; Central Region Facility – 54771C; all other provider types – 54771.
   - **Delaware:** Facility – 00070; all other provider types –00570.
   - **West Virginia:** All provider types -- 54828
6. Always report the patient's complete identification number, including the 3-character prefix.
7. Consider electronic means for claim inquiries:
   - BlueCard claims can often be found within the Claim Status Inquiry transaction in NaviNet. Remember to enter the entire identification number including the 3-character prefix; or
   - Submit a BlueExchange Inquiry via NaviNet; or
   - Initiate a HIPAA 276 transaction to Highmark.
8. Consider electronic means for utilization review inquiries:
   - Submit a BlueExchange Inquiry via NaviNet; or
   - Submit a HIPAA 278 transaction to Highmark.
9. Or, call BlueCard Eligibility **1-800-676-BLUE** (2583) for utilization inquiries. Ask to be transferred to the Utilization Review area.

What Is My Service Area?

2.6 MEDICARE ADVANTAGE PRODUCTS

Introduction

Medicare Advantage is a **separate program from BlueCard** and delivered through its own centrally-administered platform; however, since you may see members of other Blue Plans who have Medicare Advantage coverage, Medicare Advantage information is available in this manual.

Medicare Advantage overview

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as "Traditional" or "Original" Medicare). Medicare Advantage offers Medicare beneficiaries several product options (similar to those available in the commercial market), including Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service (POS), and Private Fee-For-Service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits. Many offer additional covered services as well (e.g., enhanced vision and dental benefits). Medicare Advantage plans may allow in and out-of-network benefits depending on the type of product selected. Level of benefits and coverage rules may vary depending on the Medicare Advantage plan.

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Prior to providing service, providers should always confirm the level of coverage by submitting an electronic inquiry or calling **1-800-676-BLUE** (2583) for all Medicare Advantage members.

What Is My Service Area?

Highmark's Medicare Advantage products

Highmark offers the following Medicare Advantage products:

- Freedom Blue PPO
- Community Blue Medicare HMO
- Community Blue Medicare PPO Community Blue Medicare Plus PPO

For additional information on Highmark Medicare Advantage products, please see **Chapter 2.2: Medicare Advantage Products & Programs**.

Continued on next page

2.6 MEDICARE ADVANTAGE PRODUCTS, Continued

What Is My Service Area?

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits and the coverage rules may vary by Medicare Advantage plan.

Note: Effective January 1, 2018, the Medicare Advantage HMO Network Sharing for Transplant Services program will provide all Blue Plan Medicare Advantage HMO members in-network access to Blue Plan Medicare Advantage HMO providers in other areas for transplant services. Please see the **Medicare Advantage Eligibility, Claims, and Payment** section of this unit for more information.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare Advantage HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network.

Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue Plan Medicare Advantage PPO members have in-network access to Blue Plan Medicare Advantage PPO providers in other areas. Please see the next section in this unit on "Medicare Advantage PPO Network Sharing."

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2.6 MEDICARE ADVANTAGE PRODUCTS, Continued

Medicare Advantage PFFS

A Medicare Advantage Private-Fee-For-Service (PFFS) plan is one in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays for services rendered to PFFS members. Members are responsible for cost-sharing, as specified in their plan, and balance billing may be permitted in plan-specific limited instances where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products in that:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Highmark.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan. Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions.
- Medicare Advantage PFFS Terms and Conditions might vary for each Blue Plan. We advise that you review them before servicing Medicare Advantage PFFS members.
- You may choose to render services to an out-of-area Medicare Advantage PFFS member on an episode of care (claim-by-claim) basis.
- Submit your Medicare Advantage PFFS claims to Highmark.

Note: Highmark does not offer a Medicare Advantage PFFS product.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

2.6 MEDICARE ADVANTAGE PPO NETWORK SHARING

Overview

Medicare Advantage PPO Plans are currently offered by Blue Plans in 35 states and in Puerto Rico. All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue Medicare Advantage PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue Medicare Advantage PPO Plan. As long as covered services are provided by a contracted Medicare Advantage PPO provider, the member's in-network benefit level will apply.

Identifying out-of-area members

You can recognize a Medicare Advantage PPO member when their Blue Cross Blue Shield member ID card has the following logo:

MA | PPO
MEDICARE ADVANTAGE

The "MA" in the suitcase indicates a member who is covered under the Blue Medicare Advantage PPO network sharing program. Members have been asked to not show their standard Medicare ID card when receiving services. Instead, members should provide their Blue Cross and/or Blue Shield Member ID card.

Eligibility and benefits verification

To verify eligibility and benefits for a Medicare Advantage PPO member, you can initiate a BlueExchange® Eligibility and Benefits Inquiry via NaviNet®; submit an electronic inquiry to Highmark via a HIPAA 270/271 transaction; or call the BlueCard® Eligibility Line at **1-800-676-BLUE** (2583). Be sure to ask if Medicare Advantage benefits apply.

Note: Please be sure to have the member's 3-character prefix in order to obtain eligibility information.

What Is My Service Area?

Impact to providers

If you are a contracted Highmark Medicare Advantage PPO provider in Pennsylvania or West Virginia, you must provide the same access to care for members of other participating Blue Medicare Advantage PPO Plans as you do for Highmark's Medicare Advantage PPO members. You will be reimbursed in accordance with your contracted rate under your Freedom Blue PPO contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted Highmark Medicare Advantage PPO provider, you may see out-of-area Blue Medicare Advantage PPO members but are not required to do so. Should you provide services to these members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent and emergency care, you will be reimbursed at the in-network benefit level.

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2.6 MEDICARE ADVANTAGE PPO NETWORK SHARING, Continued

Member cost sharing

A Medicare Advantage PPO member's cost sharing level and copayment is based on their health plan. A Medicare Advantage PPO participating provider in Pennsylvania or West Virginia may collect the copayment amounts at the time of service or bill for any deductibles, coinsurance, and/or copayments. However, you may not balance bill the member the difference between your charge and the Medicare Advantage PPO allowance for a particular service.

To determine the member's cost sharing, you should call the BlueCard Eligibility Line at **1-800-676-BLUE (2583)**.

What Is My Service Area?

2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT

How to recognize Medicare Advantage members

Medicare Advantage members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card.

These images illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

Medicare Advantage eligibility verification

To verify eligibility and benefits for an out-of-area Medicare Advantage member, you can initiate a BlueExchange® Eligibility and Benefits Inquiry via NaviNet®; submit an electronic inquiry to Highmark via a HIPAA 270/271 transaction; or call the BlueCard® Eligibility Line at **1-800-676-BLUE** (2583). Be sure to ask if Medicare Advantage benefits apply.

Note: Please be sure to have the member's 3-character prefix in order to obtain eligibility information.

Medicare Advantage claims submission

Medicare Advantage is a separate program from BlueCard and delivered through its own centrally-administered platform. However, claims for all out-of-area Blue Plan Medicare Advantage members are still submitted to your local Highmark plan under your current billing practices. You will receive payment from your local Highmark plan.

IMPORTANT!

Medicare should not be billed for any services rendered to a Medicare Advantage member.

Continued on next page

2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,
Continued

NAIC codes for Medicare Advantage claims submission

Claims for all out-of-area Blue Plan Medicare Advantage members can be submitted to your local Highmark plan via an electronic HIPAA 837 transaction using the applicable NAIC code for the Highmark plan with which you participate.

Please reference the following tables for NAIC codes for claim submission for Highmark Medicare Advantage products and for Medicare Advantage claims for out-of-area Blue Plans:

What Is My Service Area?

PENNSYLVANIA		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
54471W	Western Region facility type providers (UB-04/837I)	• Medicare Advantage Security Blue HMO and Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and • All Medicare Advantage claims for any other Blue Plans.
54771C	Central Region facility type providers (UB-04/837I)	• Medicare Advantage Community Blue HMO administered by Highmark Choice Company. • All Medicare Advantage claims for any other Blue Plans.
54771	All other provider types (1500/837P)	• Medicare Advantage Security Blue HMO (Western Region only) and Medicare Advantage Community Blue HMO, both administered by Highmark Choice Company. • All Medicare Advantage claims for any other Blue Plan.
15460	All provider types	• Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes **HRT** and **HRF**). • Medicare Advantage Community Blue Medicare PPO (prefixes **QLS**, **QMV**, **QJS**, **QKS**) and Community Blue Medicare Plus PPO (prefixes **FYO, FZO**).

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2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,
Continued

NAIC codes for Medicare Advantage claims submission (continued)

DELAWARE		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
00070	Facility provider types (UB-04/837I)	All Medicare Advantage claims for any Blue Plan.
00570	All other provider types (1500/837P)	All Medicare Advantage claims for any Blue Plan.

WEST VIRGINIA		
NAIC CODE	**PROVIDER TYPE**	**PRODUCTS**
54828	All provider types	All Medicare Advantage claims for any other Blue Plan.
15459	All provider types	Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with prefix **HSR**).

FOR MORE INFORMATION

For complete information on all Highmark NAIC payer codes, please see the section of this unit titled "NAIC Codes."

What Is My Service Area?

Medicare Advantage paper claims submission addresses

Submit paper claims for Highmark Medicare Advantage products and out-of-area Blue Plan Medicare Advantage members to your local Highmark plan as follows:

PENNSYLVANIA	DELAWARE	WEST VIRGINIA
Highmark Blue Shield P.O. Box 890062 Camp Hill, PA 17089-0062	Highmark Blue Cross Blue Shield Delaware P.O. Box 8830 Wilmington, DE 19899	Highmark Blue Cross Blue Shield West Virginia P.O. Box 7026 Wheeling, WV 26003

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2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,
Continued

What Is My Service Area?

Reimbursement for Medicare Advantage HMO, POS, and PPO -- with a Plan contract

If you are a Medicare participating provider in Pennsylvania or West Virginia and have a Medicare Advantage contract with Highmark, you will be reimbursed for covered services according to the Medicare fee schedule at the Medicare allowed amount when you render services to out-of-area Blue Plan Medicare Advantage HMO and POS members. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

However, if you provide services to an out-of-area Medicare Advantage PPO Network Sharing member, you will be reimbursed in accordance with your contracted rate under your Freedom Blue PPO contract.

Other than the applicable member cost sharing amounts, reimbursement is made directly by Highmark. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service and may not otherwise charge or balance bill the member. Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Note: Out-of-area Medicare Advantage HMO members are generally covered only for emergency services; however, please see below for the transplant services exception effective January 1, 2018.

Medicare Advantage HMO Network Sharing for Transplant Services—effective January 1, 2018

Blue Cross Blue Shield Association (BCBSA) policy, **effective January 1, 2018,** requires Blue Plans that offer Medicare Advantage HMO products to participate in network sharing for transplant services. Under the policy, Blue Plans with Centers for Medicare & Medicaid Services (CMS) approved transplant facilities included in their Medicare Advantage HMO networks are required to share contracted rates for transplant services with out-of-area Blue Plan Medicare Advantage HMO members.

Medicare Advantage HMO Network Sharing for Transplant Services will provide in-network access to all Blue Plans' Medicare Advantage HMO provider networks for Blue Plan Medicare Advantage HMO members who may require a transplant service outside of their home Plan's licensed service area.

Beginning January 1, 2018, transplant facilities participating in Highmark's Medicare Advantage HMO networks in Pennsylvania will be reimbursed according to their contracted Medicare Advantage HMO rate for approved transplant services for out-of-area Blue Plan Medicare Advantage HMO members. If you are a

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2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,
Continued

Medicare Advantage HMO Network Sharing for Transplant Services (continued)

contracted Highmark Medicare Advantage HMO provider, you must provide the same access to transplant services for members of other Blue Plan Medicare Advantage HMO plans as you do for Highmark's Medicare Advantage HMO members.

These members will receive in-network benefits for approved transplant services in accordance with their plan's in-network benefits, with any applicable member cost sharing applied.

What Is My Service Area?

Reimbursement for Medicare Advantage HMO, POS, and PPO -- with no Plan contract

Based on the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a Medicare participating provider who accepts Medicare assignment and you render services to a Medicare Advantage member but do not have a Medicare Advantage contract with Highmark, you will generally be considered a non-contracted provider and will be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Note: Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Reimbursement for Medicare Advantage PFFS members

If you have rendered services for a Blue out-of-area Medicare Advantage Private-Fee-For-Service (PFFS) member, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms and Conditions under the member's Blue Plan.

Medicare Advantage PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan. We advise that you review them before servicing Medicare Advantage PFFS members.

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2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,
Continued

Reimbursement for Medicare Advantage PFFS members (continued)	A link is provided on the Provider Resource Center to access the Medicare Advantage PFFS Terms and Conditions for all Blue Plans -- select **INTER-PLAN PROGRAMS** from the main menu. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member. Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

2.6 TRADITIONAL MEDICARE-RELATED CLAIMS

Overview

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is the primary payer, submit claims to your local Medicare carrier or intermediary.
- Most Blue Plan claims are set up to automatically cross over to the member's Blue Plan after being adjudicated by the Medicare intermediary.

How to submit Medicare primary / Blue Plan secondary claims

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from Highmark. Check the member's ID card for the correct Blue Plan name.

Include the prefix as part of the member identification number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage and key to facilitating prompt payments.

Review the remittance advice for confirmation

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the member's Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. **Do not submit the claim to Highmark.**
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Highmark with the Medicare remittance advice.
- In some cases, the member identification card may contain a Coordination of Benefits Agreement (COBA) ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact Highmark.

When you can expect payment

Claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed. This process may take up to fourteen (14) business days.

This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30 business days for you to receive payment from the Blue Plan.

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2.6 TRADITIONAL MEDICARE-RELATED CLAIMS, Continued

What to do if you have not received a response

If you submitted the claim to the Medicare intermediary/carrier, and have not received a response to your initial claim submission, do not automatically submit another claim. You should:

- Review the automated resubmission cycle on your claim system
- Wait thirty (30) days
- Check claim status before resubmitting

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Questions?

If you have questions, please contact Highmark Provider Services.

Quick Reference

2.6 DISCLAIMERS

Why blue italics?

Highmark Blue Shield	This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.
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