Section 8

Payment Mechanisms

Highmark Blue Shield uses several mechanisms to reimburse providers for providing services to its members. These mechanisms vary, depending on the program that the member is in.

Here is an outline of these mechanisms.

Usual, Customary and Reasonable payment

In 1965, Highmark Blue Shield introduced a payment methodology called the Prevailing Fee Program. In 1979, it was re-named as the UCR Program, or Usual, Customary and Reasonable. UCR is designed to compensate for price variations among providers and to offer affordable, full-service benefits to all members, regardless of income.

How UCR works

Highmark Blue Shield's UCR allowance is the lowest of:

- the provider's actual charge,
- the provider's usual fee, or
- the customary fee.

A reasonable allowance replaces the calculated usual or customary fee when our review process determines that the calculated usual or customary fee does not provide appropriate compensation. A reasonable allowance may be higher or lower than the calculated usual or customary fee.

How to obtain a usual fee profile

For a copy of your Highmark Blue Shield usual fee profile write to:

Highmark Blue Shield
Professional Pricing and Analysis
PO Box 890089
Camp Hill, PA 17089-0089

For more information about profiles or the data on your usual fee record, contact your Provider Relations representative.

PremierBlue Shield uses specially designed fee structure

PremierBlue Shield is Highmark Blue Shield's statewide selectively contracted network of preferred providers. It is not tied to a specific benefits program, but supports a variety of Highmark Blue Shield PPO programs.

PremierBlue Shield allowances are based on a specially developed fee schedule that emphasizes evaluation and management services. This fee structure is loosely based on the federal RBRVS-based Medicare fee schedule. In most cases, however, PremierBlue Shield's allowances are higher.

Adjustments to the PremierBlue Shield fee schedule are made, as needed, to assure providers are receiving fair reimbursement – and to assure that members have adequate access to primary care and specialty services.

PremierBlue Shield providers agree to accept Highmark Blue Shield's allowances as payment-in-full for covered services. Members are responsible for any copayments or coinsurances.

Fee schedule program payment

Fee schedules are tables of maximum allowances that Highmark Blue Shield pays. They are not intended to necessarily represent the actual value of services performed.

If the member's income falls within the specified income limits of the agreement, a Participating Provider must accept the Highmark Blue Shield allowance as payment-in-full for covered services.

Highmark Blue Shield's fee schedule agreements have the following income limits:

Program	Income limits
1800S	$6,000 for an individual $12,000 for a family
Plan C	$12,000 for an individual $24,000 for a family
Plan 5000S	$18,000 for an individual $36,000 for a family

Participating Providers initially determine whether a member is of "low income" or "over income" – except for members of our social mission programs: CHIP (Children's Health Insurance Program) and Special Care.

The member income is based on the year previous to the date of service. If there is a dispute concerning the member's income status, Highmark Blue Shield will make the final determination. (See the Social Mission Programs' payment section on the following page for more information.)

In summary, if the patient has fee schedule coverage:

And the provider is:	And the member's income is:	Then the member is responsible for:
Participating	1. Less than the limits 2. Above the limits	1. 0 2. Any unpaid balance
Non-participating	1. Less than the limits 2. Above the limits	1. Any unpaid balance 2. Any unpaid balance

By limiting provider reimbursement to the fee schedule amounts, these programs remain affordable to low-income individuals. By agreeing to accept this reimbursement as payment-in-full for eligible individuals, Highmark Blue Shield Participating Providers contribute substantially to the social mission of Highmark Blue Shield.

Social Mission Programs payment

This table shows payment levels for Highmark Blue Shield's Social Mission programs:

Program	Covered preventive services	Covered medical visits	Other covered, medical-surgical services	Hearing
CHIP (free)	HMO, UCR or PremierBlue Shield	HMO, UCR or PremierBlue Shield	HMO, UCR or PremierBlue Shield	Schedule 13
CHIP (subsidized)	HMO, UCR or PremierBlue Shield	HMO, UCR or PremierBlue Shield	HMO, UCR or PremierBlue Shield	Schedule 13
Special Care – entry tier	UCR	Plan C*	Plan C	Plan C
Special Care – second tier	UCR	UCR	UCR	UCR

**5000S schedule for procedure codes 99211-99215 (office or outpatient visits for established patients).*

Indemnity program payment

Several Highmark Blue Shield medical-surgical, dental and vision programs utilize an indemnity payment mechanism. Under this payment mechanism, covered services are reimbursed at the lower of either the actual charge submitted or the indemnity schedule for that service.

Indemnity programs differ from other fee-for-service programs in that they do not make any provision for paid-in-full benefits. Thus, all Participating and non-Participating Providers may bill the member for the difference, if any, between the indemnity fee for a given procedure and the actual charge made for that procedure.