Chapter 3

The BlueCard® Program

Unit 5: Program Overview

In This Unit

3.5 Introduction

Introduction

This unit describes the advantages of the program, and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

For more information on BlueCard participation, please visit the BlueCard section of Chapter 3.1 in the Highmark Blue Shield Office Manual by hovering over Administrative Reference Materials on the Provider Resource Center.

BlueCard Participation

As a participating provider of Highmark Blue Shield you may render services to patients who are national account members of other Blue Plans, and who travel or live in Pennsylvania.

In Pennsylvania, the BlueCard networks include:

- Participating Provider network (supports all Blue Card programs for members that usually live outside their Blue Plan's service area with traditional, POS and HMO coverage.
- PremierBlue Shield network (supports the BlueCard PPO programs for members that usually live outside their Blue Plan's service area in a PPO plan).

3.5 What Is The BlueCard Program?

Definition

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

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Highmark Blue Shield is your sole contact for claims submission, payment, problem resolution and adjustments.

BlueCard Program Advantages To Providers

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

Highmark Blue Shield continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

Accounts Exempt From The BlueCard Program

The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Prescription drugs and
- The Federal Employee Program (FEP)

***Please visit Chapter 5, Unit 2 of the Highmark Blue Shield Office Manual for more information on FEP.*

Please follow Highmark Blue Shield billing guidelines.

3.5 How The BlueCard Program Works

Member ID Cards

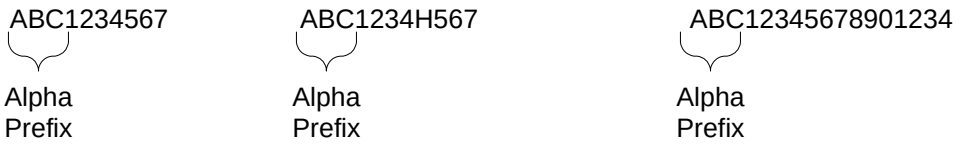
When members of Blue Plans arrive at your office, be sure to ask them for their current Blue Plan membership identification card.

The main identifier for out-of-area members is the alpha prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo
- Important facts concerning member IDs:
  - A correct member ID number includes the alpha 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 numbers/letters following the alpha prefix.
  - Do not add/delete characters or numbers within the member ID.
  - Do not change the sequence of the characters following the alpha prefix.
  - The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID number.

Examples of ID numbers:



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 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.

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 numbers.

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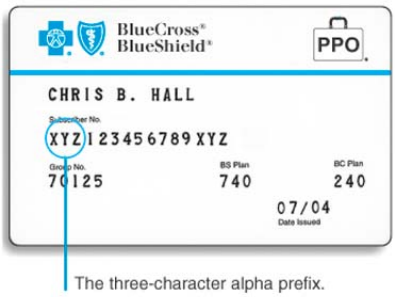
3.5 How The BlueCard Program Works, continued

Alpha Prefix

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

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff.

Do not make up alpha prefixes. Do not assume that the member's ID number is the social security number. As of 2006, nearly all Blue Plans have replaced Social Security numbers on member ID cards with an alternate, unique identifier.



The "suitcase" logo may appear anywhere on the front of the card.

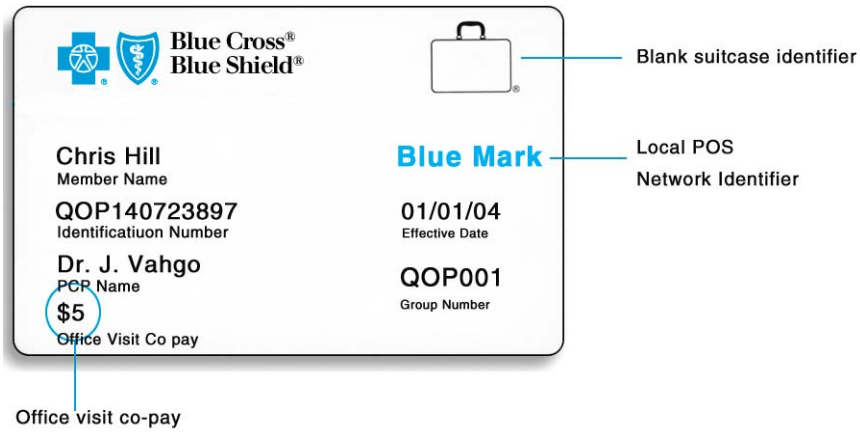
3.5 How to Identify BlueCard Managed Care/POS Members

How To Identify BlueCard Managed Care/POS 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, in the BlueCard Managed Care/POS members are enrolled in Highmark Blue Shield network and have a primary care physician (PCP). You can recognize BlueCard Managed Care/POS members who are enrolled in the Highmark Blue Shield network through the member ID card as you do for all other BlueCard members.

The ID cards will include:

- The three-character alpha prefix at the beginning the member's ID number.
- A local network identifier and
- The blank suitcase logo



3.5 How To Identify International Members

Foreign Identification Cards

Occasionally, you may see identification cards from foreign Blue members. These ID cards will also contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.

NOTE: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the U.S. Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Plans and those, if any, on their ID cards for servicing their members.

The Blue Cross Plans in Canada are:

Alberta Blue Cross	Atlantic Blue Cross Care	Saskatchewan Blue Cross
Manitoba Blue Cross	Quebec Blue Cross	Pacific Blue Cross

Sample Foreign Identification Card

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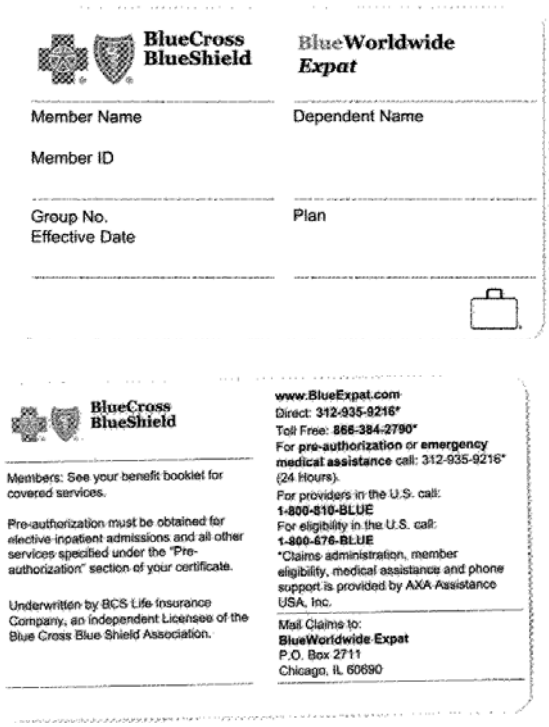
3.5 How To Identify International Members, Continued

Sample image of the U.S. Blue member's residing abroad card:



If you are unsure about your participation status, call Highmark Blue Shield.

3.5 Consumer Directed Health Care and Health Care Debit Cards

Overview

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

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

Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

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 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

The card will have the nationally recognized Blue logos, along with the logo from a major debit card logo such as MasterCard® or Visa®.

3.5 Consumer Directed Health Care and Health Care Debit Cards, Continued

Card Details

The cards include a magnetic strip so that providers can swipe the card at the point of service to collect the member cost-sharing amount (i.e. copayment, deductible, etc.). With health debit cards, members can pay for other out-of-pocket expenses by swiping the card though 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

- Carefully determine the member's financial responsibility before processing payment. You can access the member's accumulated deductible by using online electronic capabilities services or by contacting the BlueCard Eligibility line at 1.800.676.BLUE (2583).
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out of pocket amounts before processing payment:
  - Many plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member's benefits or to request accumulated deductible information use electronic capabilities or, contact 1.800.676.BLUE (2583).
  - You may use the debit card for member responsibility for medical services provided in your office.
  - You may choose to forego using the debit card and submit the claims to Highmark Blue Shield for processing. The Remittance Advice will inform you of member responsibilities.
  - All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to the local Plan for proper benefit determination, and to update the member's claim history.

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3.5 Consumer Directed Health Care and Health Care Debit Cards, Continued

Helpful Tips, continued

- If you have any questions about the member's benefits, check eligibility and benefits electronically or contact 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.

Coverage and Eligibility Verification

For other Blue Plans' members, submit an electronic inquiry to Highmark Blue Shield or call BlueCard Eligibility (1.800.676.BLUE) to verify the patient's eligibility and coverage:

- Electronic options:
  – Initiate a Blue Exchange inquiry from within NaviNet

- Submit a HIPAA 270 transaction (eligibility) to Highmark Blue Shield.

  You can receive real-time responses to your eligibility requests for out-of-area members between 7:00am and 1:00 a.m., Eastern Standard Time, Monday through Saturday.

- Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583)
  - English and Spanish speaking phone operators are available to assist you.
  - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than Highmark Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.
  - The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. See the Claim Filing section for claim filing information.

3.5 Utilization Review

Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/ preauthorization for their services from their Blue Plan.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

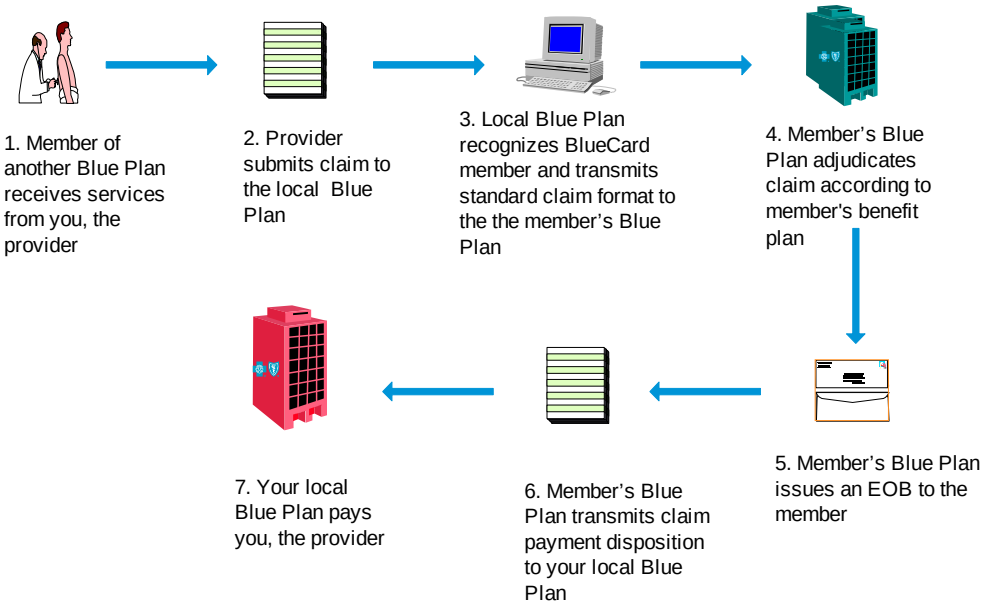
**You may also contact the member's Plan on the member's behalf for authorization. See pages 28-29 for more details.

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.

3.5 Claim Filing

How Claims Flow Through BlueCard

Below is an example of how claims flow through BlueCard.



NOTE: You should always submit claims to Highmark Blue Shield and use NAIC code 54771 as the payer code in the 837 Health Care Claim transaction.

Helpful Tips

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 alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits. See pages 28-29 for more details.
- Verify the member's cost sharing amount before processing payment.

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3.5 Claim Filing, Continued

Helpful Tips, continued

- Indicate on the claim any payment you collected from the patient.
  - On the 837 electronic claim submission form, check field AMT01=**F5** patient paid amount;
  - On the CMS1500 locator Box **29** amount paid; this is the total of patient and other payer(s) prior paid, not just patient prior paid.
- Submit all Blue claims to Highmark Blue Shield. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character alpha prefix. Submit claims with only valid alpha-prefixes; claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.

International Claims

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to Highmark Blue Shield. See section on 'How to Identify Members' in this unit on servicing members of the Canadian Blue Cross Plans.

Coding

Code claims as you would for Highmark Blue Shield claims.

Adjustments

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

- Search for the claim in question via the Claims Status Inquiry within NaviNet and then initiate an adjustment request via the Claims Investigation section.
- Non-NaviNet enabled providers should submit adjustments electronically via the HIPAA 837 transaction if your office system is capable.

Appeals

Appeals for all claims are handled through Highmark Blue Shield. We will coordinate the appeal process with the member's Blue Plan, if needed.

Appeals for out-of-area Medicare Advantage members are handled by the member's Blue Plan. Initiate your appeal by contacting the Customer Service phone number on the member's identification card.

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3.5 Claim Filing, Continued

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 that one health plan, and:

- Highmark Blue Shield or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to Highmark Blue Shield. 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.
- Other non-Blue health plan is primary and Highmark Blue Shield or any other Blue Plan is secondary, submit the claim to Highmark Blue Shield only after receiving payment from the primary payor, 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.
- 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). Highmark Blue Shield standard time for claims processing is Highmark Blue Shield's standard or policy. However, claim processing times at various Blue Plans vary.
- If you do not receive your payment or a response regarding your payment, please visit NaviNet or call Highmark Blue Shield Provider Service 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 Blue Shield may either ask you for the information or give the member's Plan permission to contact you directly.

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3.5 Claim Filing, Continued

Claim Status Inquiry

Highmark Blue Shield is your single point of contact for all claim inquiries. See pages 28-29 for details.

Calls From Members And Others With Claim Questions

If members contact you about a claim resolution, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

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

Key Contacts

For more information:

- Visit the Blue Card Information Center within the Provider Resource Center Web site
- Call Highmark Blue Shield
- Contact your provider relations representative

3.5 Special Considerations for Claims Filing

Claims Filing Tips for Border County Providers

Do you practice in a county bordering another state and have contracts with Blue Plans in your home state (based on your physical location) and the neighboring state? If so, you should file all claims with Highmark Blue Shield, based on where you provided the service, except when a member has coverage with the neighboring state's Blue Plan.

Below please find examples using various Plans that border our state. The examples would be the same regardless of which state you may border with.

Examples #1 of Border Plans

Example 1:

Provider has contracts with Blue Plans in two bordering states.

A provider is located in a Georgia county that borders Alabama and has contracts with Blue Plans in both states.

- When this provider renders a service to an Alabama member, the claim is filed with Alabama.
- All other claims are filed with Georgia.

Example #2 of Border Plans

Example 2:

Provider has a contract only with the local Plan in the home state.

A provider is located in a Georgia county that borders Alabama and has a contract only with Georgia.

- All claims are filed with Georgia.

3.5 Special Considerations for Claims Filing, Continued

Example #3 of Border Plans

Example 3:

Provider does not have a contract with the local Blue Plan in the home state, but has a contract with the Blue Plan in a neighboring state.

A provider is located in a Georgia county that borders Alabama. The provider doesn't have a contract with Georgia, but has a contract with Alabama.

- When this provider renders a service to an Alabama member, the claim is filed with Alabama.
- All other claims are filed with Georgia.

3.5 Medicare Advantage Claims

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 Medicare").

It 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, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

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.

Medicare Advantage plans may allow in-and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by submitting an electronic inquiry or calling 1.800.676.BLUE (2583) for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans – Medicare Advantage HMO

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.

Types of Medicare Advantage Plans – Medicare Advantage POS

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare 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.

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3.5 Medicare Advantage Claims, Continued

Types of Medicare Advantage Plans – 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.

Types of Medicare Advantage Plans – Medicare Advantage MSA

A Medicare Advantage MSA is a Medical Savings Account. This plan has two parts. The first part is a high-deductible Medicare Advantage MSA Health Plan. This health plan won't begin to pay covered costs until you have met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that the beneficiary may use to pay health care costs.

Types of Medicare Advantage Plans – Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan 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 provider is considered by CMS to be 'deemed' when the provider has reviewed the Terms & Conditions for the member's plan and/or treated the member. *To view the PFFS Terms and Conditions, please select Medicare Advantage PFFS from the Administrative Reference Materials menu on the Provider Resource Center or visit the Appendix of the Highmark Blue Shield Office Manual.*

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instances. The applicable instances are plan-specific.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- *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.*

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3.5 Medicare Advantage Claims, Continued

Types of Medicare Advantage Plans – Medicare Advantage PFFS, *continued*

- *Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.*
- *MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan and we advise that you review them before servicing MA PFFS members.*
- *For your convenience, effective January 1, 2008, you will find MA PFFS Terms and Conditions for all Blue Plans on the Provider Resource Center under Administrative Reference Materials by providing the member's three-letter alpha prefix*
- *Submit your MA PFFS claims to Highmark Blue Shield.*

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.

How To Recognize Medicare Advantage Members

Members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

MEDICARE ADVANTAGE | PPO

MEDICARE ADVANTAGE | MSA

MEDICARE ADVANTAGE | PFFS

MEDICARE ADVANTAGE | HMO

MEDICARE ADVANTAGE | POS

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3.5 Medicare Advantage Claims, Continued

Eligibility Verification	Verify eligibility by initiating a BlueExchange via NaviNet, submitting an electronic inquiry via HIPAA 270/271 transaction or by contacting 1.800.676.BLUE (2583) and providing an alpha prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to your Provider Relations Representative.
Medicare Advantage Claims Submission	Submit all Medicare Advantage claims to Highmark Blue Shield. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan.
Reimbursement For Medicare Advantage PPO, HMO, POS	**No Plan Contract: Services for out-of-area and local Medicare Advantage members** [Situation below is where the provider does not have a contract with local Plan for MA and provides service to a local or out-of-area MA member.] Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a Medicare participating professional provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and CMS regulations require payment be made at the Medicare equivalent amount for 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.

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3.5 Medicare Advantage Claims, Continued

Plan Contract: Services For Local Blue Medicare Advantage Members

[Situation below is where the provider has a contract with the local Plan for MA and provides service to a local Blue MA member.]

If you are a provider who accepts Medicare assignment and you render services to a local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

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.

Plan Contract: Services For Out-Of-Area Medicare Advantage Blue Members

[Situation below is where the provider has a contract with the local Plan for MA and provides services for out-of-area Blue MA members.]

If you are a Medicare participating provider and have a Blue Plan contract to provide services for local Medicare Advantage enrollees only, and you render services to out-of-area Blue Medicare Advantage members, PPO, HMO, and POS members, you will be reimbursed for covered services according to the Medicare fee schedule at the Medicare allowed amount (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 and their individual Plan contractual arrangements.

NOTE: Out-of-area Medicare Advantage HMO members are covered only for emergency services.

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.

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3.5 Medicare Advantage Claims, Continued

Services For Out-Of-Area Blue Medicare Advantage PFFS Members

[Situation below is where the provider renders services for out-of-area MA PFFS members.]

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, you will be reimbursed for covered services according to the Medicare fee schedule at the Medicare allowed amount (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.

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.

3.5 Traditional Medicare Related Claims

Traditional Medicare Related Claims

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

- When Medicare is primary payor, submit claims to your local Medicare carrier or intermediary.
- It is not necessary for you to file the secondary claim to Highmark Blue Shield because Highmark has established a nationally standard contract with CMS that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data. CMS will transfer the claims crossover functions from individual Medicare contractors to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This consolidation will allow for the establishment of unique identifiers (COBA IDs) to be associated with each contract and create a national repository for COBA information
- If you use Other Carrier Name and Address (OCNA) number on a Medicare claim, ensure it is correct for the member's Blue Plan. Do not automatically use the OCNA number for Highmark Blue Shield or create an OCNA number of your own. In addition, do not create alpha prefixes. For an electronic HIPAA 835 (Remittance Advice) request on Medicare-related claims, contact Highmark Blue Shield.
- Do not send duplicate claims.

3.5 Medical Records Requests

Medical Records Requests

There are times when the member's Blue Plan will require medical records to review the claim. These requests should come from Highmark Blue Shield. Please forward all requested medical records to Highmark Blue Shield and we will coordinate with the member's Blue Plan. Please direct any questions or inquiries regarding medical records *to Highmark Customer Service at 1-866-731-8080.*

IMPORTANT: Please do not proactively send medical records with the claim, unless requested. Unsolicited claim attachments may cause claim payment delays.

3.5 BlueCard Quick Tips

BlueCard Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Cross and/or Blue Shield Plans with your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
- Consider electronic means first for eligibility inquiries:
    - Submit a BlueExchange inquiry via NaviNet
    - Submit a HIPAA 270 transaction to Highmark
- Or, call 1-800-676-BLUE
    - English and Spanish operators are available
    - Because of the time zone difference coast to coast, you may sometimes reach a voice response system linked to enrollment and benefits
- Submit the claim to Highmark Blue Shield using NAIC code 54771. Always report the patient's complete identification number, which includes the three-character alpha prefix.

Consider electronic means first for claims inquiries:

- BlueCard claims can often be found within the claims status inquiry transaction within NaviNet (remember to enter the entire identification number including the alpha prefix)
- Submit a BlueExchange inquiry via NaviNet.
- Initiate a HIPAA 276 transaction to Highmark

Consider electronic means first for utilization review inquiries:

- Submit a BlueExchange inquiry via NaviNet.
- Submit a HIPAA 278 transaction to Highmark
- Or, call 1-800-676-BLUE

Ask to be transferred to the Utilization Review area

3.5 How to Inquire About Eligibility, Benefits, Claims and Submit Authorization Requests for BlueCard Members

Highmark Blue Shield Is Your One-Stop Shop

Provider satisfaction is our top priority. We understand you need the right tools and resources to provide the best care to Blue members, so to help you obtain information for both our members and out-of-area Blue members there are several options available to assist you with administrative processes. Always look to Highmark Blue Shield first when you need help with information about out-of-area members.

Electronic Transactions Preferred

Because of the inherent speed and cost-effectiveness, electronic transactions and online communications are integral to today's business world. Electronic transactions between health care professionals and insurers are essential to maintain efficiency and are, in fact, encouraged by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NaviNet

To view out-of-area claims electronically you must use the alpha-prefix in addition to the member's identification number.

Electronic eligibility, benefits, and authorizations for out-of-area members are available only via the Blue Exchange transactions initiated within NaviNet.

BlueExchange

BlueExchange simplifies your exchanges for out-of-area members using HIPAA-compliant transactions. The Blue Cross Blue Shield Association developed BlueExchange as a gateway for routing inquiries about out-of-area members between providers and the member's Blue Plan. BlueExchange transactions submitted through Highmark Blue Shield are routed to the member's Blue Plan based on the alpha prefix.

There are three primary types of inquiries that can be routed via BlueExchange: Eligibility and Benefits, Claim Status, and Authorization Requests. Each of these transactions can be initiated within NaviNet. Look for the "BlueExchange (Out-Of-Area) selections from the dropdown menu; you will see a fly-out with each individual selection.

Use Blue Exchange claims status inquiry to search for out-of-area Medicare cross-over claims or those filed directly to the home plan.

Continued on next page

3.5 How to Inquire About Eligibility, Benefits, Claims and Submit Authorization Requests for BlueCard Members,
Continued

HIPAA Transactions

The following transactions can be submitted to Highmark Blue Shield for out-of-area members via your practice management software if your office has this capability:

- 270 for eligibility and benefits
- 276 for claim status
- 278 for utilization review

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

Toll-Free Number Also Available

Call BlueCard Eligibility 1-800-676-BLUE (2583).

- English and Spanish speaking phone operators are available to assist you.
- Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule that Highmark Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.

The BlueCard Eligibility line is only for:

- Eligibility
- Benefit
- Pre-certification/referral authorization inquiries

This number should not, however, be used for claim status.

3.5 BlueCard Provider Surveys

Tell Us What You Think!

One of our top goals is to keep Blue members and providers satisfied with the service we provide. To help us evaluate our performance and assess your satisfaction with the BlueCard Program, two provider surveys are conducted each year. If your office is contacted by the research vendor, we encourage you to participate. The vendor will ask to speak with a staff member who has broad knowledge of BlueCard claims filing and/or billing.

Your feedback helps us focus on the initiatives that make a difference to you.