




**Facility/Professional**  
**GENERAL OVERVIEW**  
**for new providers**







# Agenda



## Welcome

-  Highmark Service Areas
-  Sample ID Cards
-  Product Offering

## Claims

-  Claims Submission
-  Claims Reimbursements
-  Claims Inquiries
-  Coordination of Benefits


## BlueCard<sup>®</sup>

-  BlueCard Program Overview
-  BlueCard Claims Submission

## Medical Management & Utilization Review

-  Eligibility of Services
-  Utilization Management
-  Authorizations
-  Medical Management Partners
-  BlueCard & Third-Party Administrator Members

## Resources

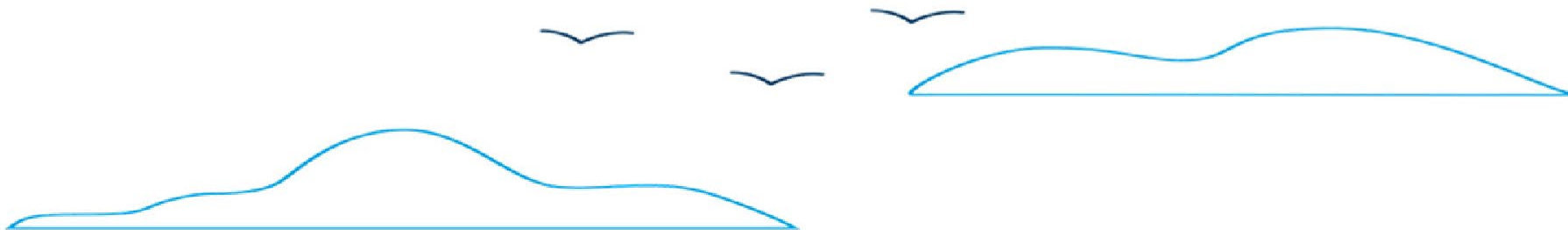
-  Communication Channels



# Welcome to





An Independent Licensee of the Blue Cross and Blue Shield Association

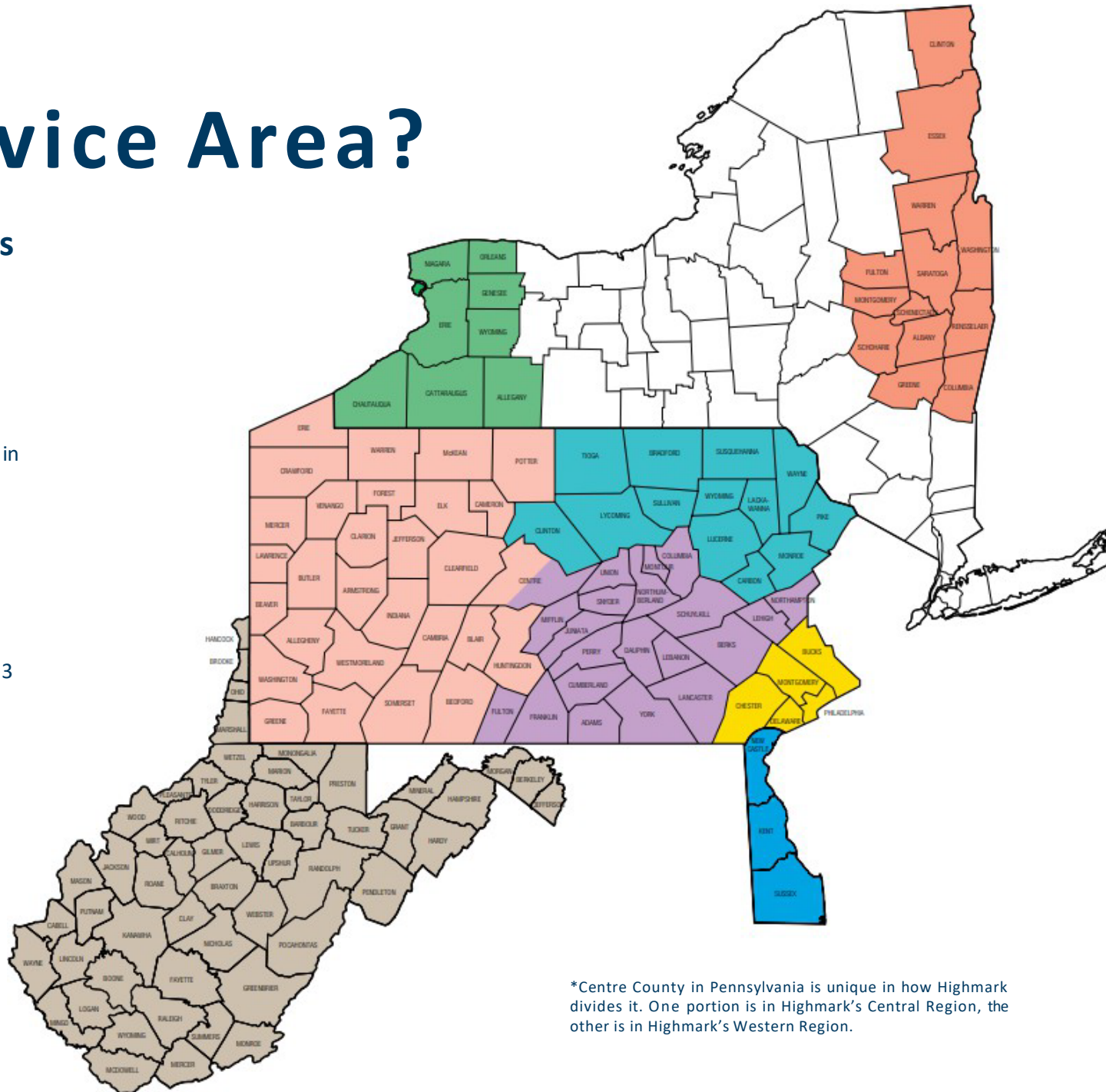




# What Is My Service Area?

Highmark defines its service areas as outlined in the maps.

-  **Delaware (DE)** – All 3 counties in Delaware
-  **New York Northeastern Region (NENY)** – Serves 13 counties in northeastern New York
-  **New York Western Region (WNY)** – Serves 8 counties in western New York
-  **Pennsylvania Western Region (WPA)** – Serves 29 counties in western Pennsylvania\*
-  **Pennsylvania Central Region (CPA)** – Serves 21 counties in central Pennsylvania\*
-  **Pennsylvania Northeastern Region (NENY)** – Serves 13 counties in northeastern Pennsylvania
-  **Pennsylvania Southeastern Region (SEPA)** – Serves 5 counties in southeastern Pennsylvania
-  **West Virginia (WV)** – All 55 counties of West Virginia
-  **Not included in Highmark Service Areas**




\*Centre County in Pennsylvania is unique in how Highmark divides it. One portion is in Highmark's Central Region, the other is in Highmark's Western Region.



# Sample ID Cards

[How to locate information on the Member ID: Highmark Sample ID Cards](#)

## SEPA Direct Pay (PPO)



**HIGHMARK** BENEFITS GROUP  My Blue Access PPO


**ROBERTCARDTEST/TESTCARD**  
ELS513383976001

Effective 2024  
DEPENDENT

**ROBERTCARDTEST/TESTCARD**  
Group 10792031  
BS Plan 376  
RxGrp HMRK001  
RxBIN 610014  
Pediatric Dental  
Pediatric Vision

Deductible/Coinsurance may apply  
PCP \$75  
SP \$75  
ER \$750  
Ind Ded \$2900  
Fam Ded \$5800  
Ind OOP \$8500  
Fam OOP \$17000  
Out of Network  
Ind Ded \$5800 Fam Ded \$11600  
Ind OOP \$17000 Fam OOP \$34000


 myhighmark.com

Providers: File medical claims to the local BC/BS plan.  
Members: File claims to:  
**Medical Claims**  
P.O. Box 890118  
Camp Hill, PA 17089-0118  
**Dental Claims**  
P.O. Box 69444  
Harrisburg, PA 17106  
**Vision Claims**  
P.O. Box 1525  
Latham, NY 12110  
All in and out of network inpatient admissions and certain outpatient medical services require authorization.

Member Service 1-888-510-1084  
TTY/TDD Service Dial 711  
Dental (United Concordia)\* 1-866-568-6008  
Vision (Davis Vision)\* 1-800-223-4795  
Nurse Line 1-888-BLUE-428  
Call for Precertification:  
Mental Health 1-888-510-1084  
Substance Abuse 1-888-510-1084  
Other Admissions 1-888-510-1084  
\*Administrator of plan.

Highmark Benefits Group Inc. is an independent licensee of the Blue Cross Blue Shield Association.



## SEPA Freedom Blue (PPO)


**HIGHMARK** SENIOR HEALTH COMPANY  Freedom Blue PPO Valor

MEMBER NAME  
**MEDADV TESTCARD**  
MEMBER ID  
**FAS123456789001**  
PLAN (80840) 9151014609

Group 01988065  
BS Plan 376  
RxBIN 610014  
RxPCN MEDDPRIME  
RxGrp SPBLUE1  
RxFormulary Incentive Rx

Hearing/Vision/Dental  
In \$0  
Office Visit \$10  
Specialist Visit \$125  
Emergency Room \$125  
CMS H3916 806

 medicare.Highmark.com

Member Service 1-800-550-8722  
Blues on Call 1-888-258-3428  
TTY/TDD Service Dial 711  
UM 1-800-452-8507

Blues on Call: 24-hour access to nurses who provide health education and support services.  
To receive high level benefits: Receive care from a network provider. Receiving non-emergency care from an out-of-network provider will result in a reduced level of benefits. Medicare limiting charges apply.  
Call Utilization Management (UM) for authorizations and eligibility.  
Pre-certification required for non-emergent inpatient admissions and certain outpatient services.

All medical claims should be submitted to the local BC/BS plan.  
Highmark Senior Health Company is an Independent Licensee of the Blue Cross and Blue Shield Association.

Express Scripts  
A1TN, Medicare Part D  
P.O. Box 14718  
Lexington, KY 40512-4718

Pharmacy benefit administrator

## Highmark Blue Cross Blue Shield Example (not specific to SEPA)

**HIGHMARK**  BlueCare HMO

MEMBER IDENTIFICATION  
FIRST NAME  
LAST NAME  
YYU109465762001

PCP INFORMATION  
GREENTREE MED  
724-555-1212 01/01/2016

Group 01234567  
BC/BS Plan 377/877  
RxGrp HMRK001  
RxBin 610014

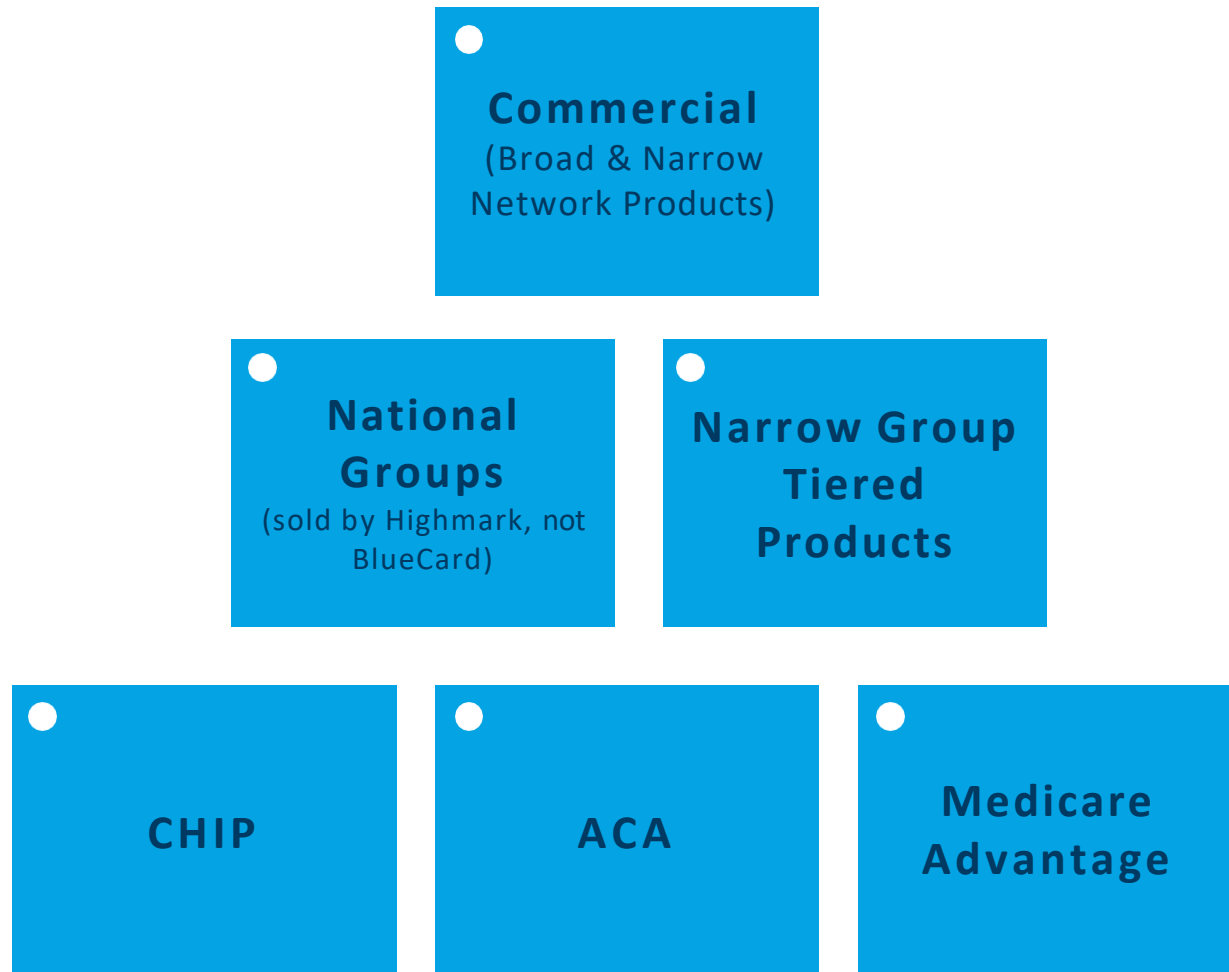
Medical Copays  
Office Visit \$10  
Specialist Visit \$10  
Emergency Room \$35







# Products That Highmark Offers...



**New Provider Training:**  
**Claims**



# Claims Submission

## NAIC Codes

- Commercial Products
  - Facility providers (UB-04/ 837I): **54771S**
  - All other provider types (1500/ 837P): **54771**
- Medicare Advantage Products
  - All provider types: **15460**



All claims are to be submitted electronically

## Vendor, Trading Partner, Software Submissions

- Contact Highmark EDI  
**(800) 992-0246**



## Billing Formats and Protocols

- Refer to the Highmark Provider Resource Center:  
<https://providers.highmark.com>

FEP (Federal Employee Program) member claims must be submitted directly to the home plan.





# Claims Reimbursements



ECHO Health is utilized to issue electronic reimbursements



Set up an account directly: <https://www.echohealthinc.com/provider>



For assistance signing up for the ECHO Provider Portal, access the user guide: [Provider Payments Portal Quick Reference Guide](#)



Additional Assistance is available via an instructional video: [PNC ECHO Provider Portal Demo on Vimeo](#)



# Claims Inquiries

For all Claims Investigations and Inquiries

Use Availity

Upload any pertinent documentation via Claim Status > Message This Payer

For Adjustments\*

Use Electronic Vendor Submission or Availity

Submit a corrected claim using Adjustment Bill Types XX5, XX7, XX8

**⚠ Never send a check for a refund ⚠**



# Coordination of Benefits

## Medicare Crossover

- Highmark Medigap claims will cross over from CMS
- Must allow 30 days from Medicare Crossover prior to re-submitting a Medigap claim

## Secondary/Tertiary Coverage

- Standard UB-04 requirements
- Use appropriate CAS Codes
- Paper EOBs/remittances are not required
- Highmark services requiring authorization must have an authorization on file even if the service is secondary or tertiary to another carrier(s)

**New Provider Training:  
BlueCard  
and Medicare Advantage  
PPO Network Sharing**



# BlueCard<sup>™</sup> and MA PPO Network Sharing

Use Highmark as your contact for all aspects of Claims Processing

## Submit to Local Plan

- If your patient's identification card includes a Blue Cross and Blue Shield service mark, and you do not participate with that member's Home Plan, it may be submitted to Highmark Blue Shield.

## Investigation/Inquiry

- Submit claim inquiries via Availity.
- Do not contact the Home Plan for inquiries submitted through Highmark.

## Payment

- You will receive Reimbursement at your Highmark contracted rate.
- You will receive it on your Highmark Electronic Transmittal/Remittance.



# BlueCard<sup>®</sup> and MA PPO Network Sharing

## What are these programs?

BlueCard<sup>®</sup> allows access for Out-of-Area Members to your facilities.

**MA PPO Network Sharing:** Similar to BlueCard<sup>®</sup>, all Blue Medicare Advantage PPO plans participate in reciprocal network sharing.

## What does the PPO or MA PPO Suitcase logo signify?



The “suitcase” logo on a member’s card indicates that they are participating in a BlueCard Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), or Medicare Advantage PPO plan.

## Additional Information:

- Members’ Home Plan dictates eligibility for out-of-network services.
- Members receive no benefits for care obtained outside the network (except emergency care).
- FEP (Federal Employee Program) members are excluded from these programs and their claims must be submitted directly to the home plan.
- Members’ ID cards include information on the back, stating that these members have no or limited benefits, except when receiving services from a BlueCard PPO provider.



# BlueCard<sup>®</sup> and MA PPO Network Sharing

To determine benefits and eligibility for out-of-area patients:

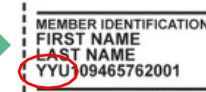
Call the **Home Plan** using the number on the member's ID card

Call BlueCard<sup>®</sup> eligibility  
**1 (800) 676-BLUE (2583)**

Online via **Availity**, through Blue Exchange

The main identifiers for BlueCard<sup>®</sup> Members are:

The **Alpha Prefix**: used to identify the Blue Plan or national account to which the member belongs



The **blank suitcase logo** on the ID card: means the member has traditional, Point of Service, or HMO benefits and would use the Participating Provider Network



The **PPO in a suitcase logo** on the ID card: means the member has PPO or EPO benefits and would use the PremierBlue Shield network



The **MA in a suitcase logo** on the ID card: means they are a Medicare Advantage PPO member







# BlueCard<sup>®</sup> and MA PPO Network Sharing

Not all BlueCard<sup>®</sup> products share network eligibility  
(HMOs and EPOs)

**Be sure to ask:**

- 1 Is the facility in-network for the member's product?
- 2 Does the patient require additional referral/ authorization for services outside the home network?
- 3 Does the patient have any additional co-insurance or deductible for services outside the home network?



# BlueCard and MA PPO Network Sharing Claims Submission



## NOTES

- A claim cannot be sent to **both** Highmark and IBC
- Claim adjudication and follow-up must be completed with the plan in which the claim was submitted

**New Provider Training:**  
**Medical Management &  
Utilization Review**



# Eligibility of Services

Eligibility of services is determined by:



**Member Benefits**



**Medical Policy**



**Medical Necessity**



**Authorizations**



# Utilization Management

*Diagnosis code and procedure code on authorization must match the submitted claim.*

Use  **Availity®** for all authorization needs

1

## Authorizations

- Verify Member Eligibility and Benefits
- Verify Medical Policy
- Verify Vendor Authorization Procedures and Policies
- Verify Codes for Requiring Authorization

2

## Retrospective Review

- For services performed but not authorized prior to the rendering of the service, Retrospective Reviews need to be pursued
- Contact Highmark for all Retrospective Services
- Contact Vendor for all Vendor Managed Authorizations

3

## Appeals

- If a claim has been submitted, utilize secure messaging on Availity to pursue appeals on authorization denials
- Upload all appropriate documentation with the appeal
- Appeals need to be submitted within 180 days of the authorization denial date, unless the member contract specifies a different timeframe

4

## Peer-to-Peer\*

- If member benefits allow for Peer-to-Peer reviews, contact 844-945-5525 to schedule a Peer-to-Peer review
- Investigational/Experimental Services
    - Fully insured products are eligible for Peer-to-Peer reviews
    - Self-insured groups may be eligible based upon group benefits.



# Utilization Management

*Diagnosis code and procedure code on authorization must match the submitted claim.*

Use  **Availity<sup>®</sup>** for all concurrent and discharging needs

1

## Concurrent Reviews

- Can be completed on Availity

2

## Discharge Planning

- Can be completed on Availity




# Authorizations



[www.Availity.com](http://www.Availity.com)

The **fastest** and **most accurate** means of entering & managing authorizations

Always use Availity first. If your issue cannot be resolved using Availity, you can utilize the following alternate forms of communication:


 **(800) 452-8507**

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UM Team (for clinical issue resolution)

Availity provides all status information on authorizations

Inpatient Faxes\*

 **(800) 416-9195**

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PA Highmark members

 **(877) 650-6069**

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DE Highmark members

Outpatient Faxes\*

 **(888) 236-6321**

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PA Highmark members

 **(800) 670-4862**

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DE Highmark members

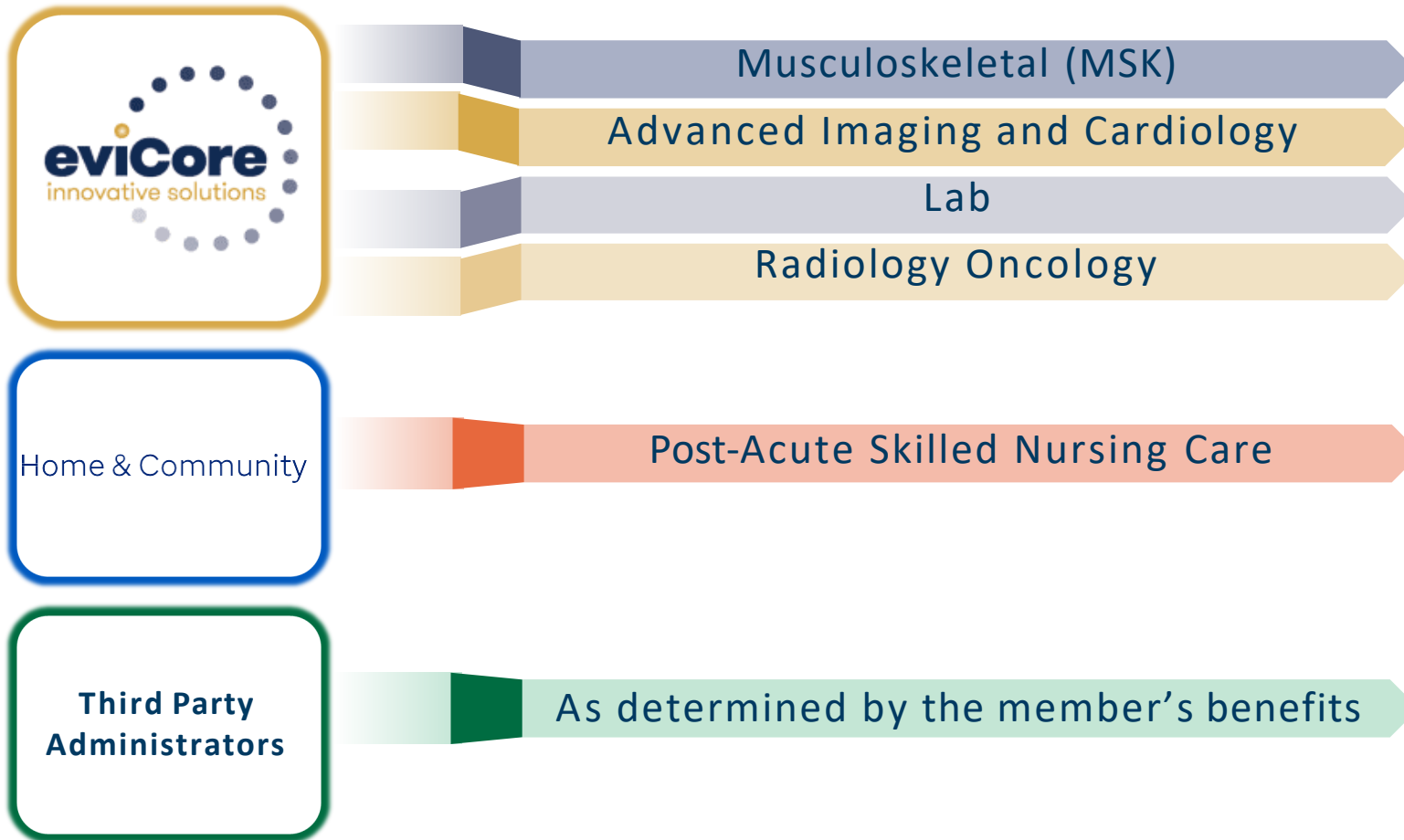
\*Faxing should be utilized ONLY when electronic submissions are not available. Please indicate proper return fax numbers in all fax submissions.





# Medical Management Partners

*Our partners in Member Care*





# BlueCard and Third Party Administrator Members

All medical management is coordinated with the member's Home Plan/TPA

Medical management, Medical Policy, and Final Determinations of eligibility are determined by the member's Home Plan/TPA. Highmark Policy is not applied

Provider appeals are submitted to the Local Plan. Peer-to-Peer reviews can be submitted to the Local Plan or directly to the Home Plan/TPA

**New Provider Training:  
Resources**



# Communication Channels for Providers

<https://providers.highmark.com>

- Credentialing
- Highmark Provider Manual
- Reimbursement Policy Information
- Bulletins, Newsletters, and Updates
- Authorization Information
- Medical Policy Information

**Provider  
Resource  
Center**

**Highmark  
Provider  
Portal-  
Availity**

[www.availity.com](http://www.availity.com)

- Credentialing
- Eligibility and Benefits
- Submitting Authorizations
- Claims Research
- Provider Investigations
- Uploading Documents



**(844) 945-5525**

Mon-Fri 8am-5pm

**Provider  
Services**

**Self-  
Service  
Hub**


<https://providers.highmark.com>

- Available on the Provider Resource Center
- Details on Highmark's Self-Service tools
- Escalation path for issues




# Communication Channels


Provider Resource Center (PRC)  
<https://providers.highmark.com>


 Credentialing Forms

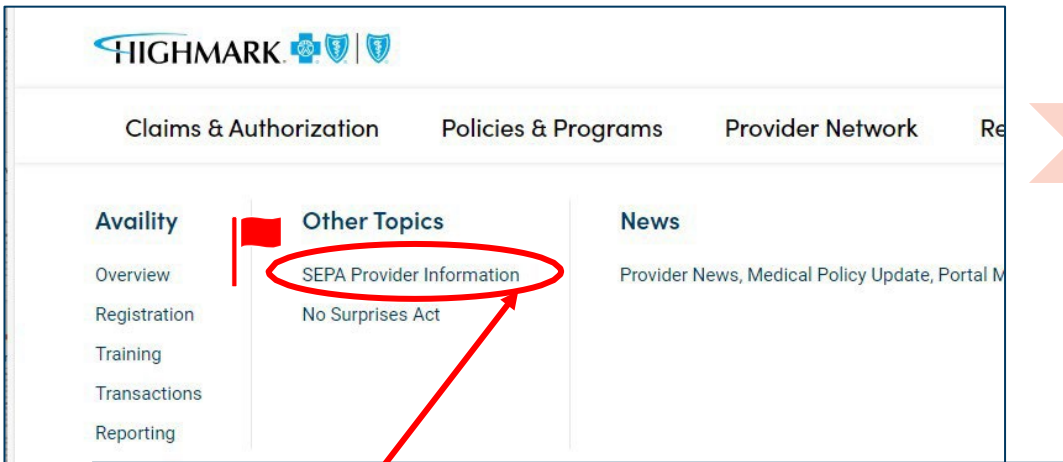
 Highmark Provider Manual


 Reimbursement Policy Information

Bulletins, Newsletters, and Updates 

Authorization Information 

Medical Policy Information 



HIGHMARK 

Claims & Authorization   Policies & Programs   Provider Network   Re

Availity   **Other Topics**   News

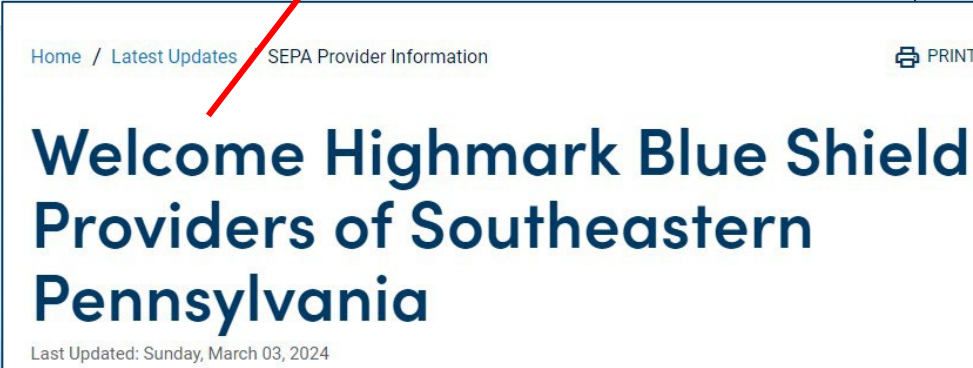
Overview   **SEPA Provider Information**   Provider News, Medical Policy Update, Portal M


Registration   No Surprises Act

Training

Transactions

Reporting

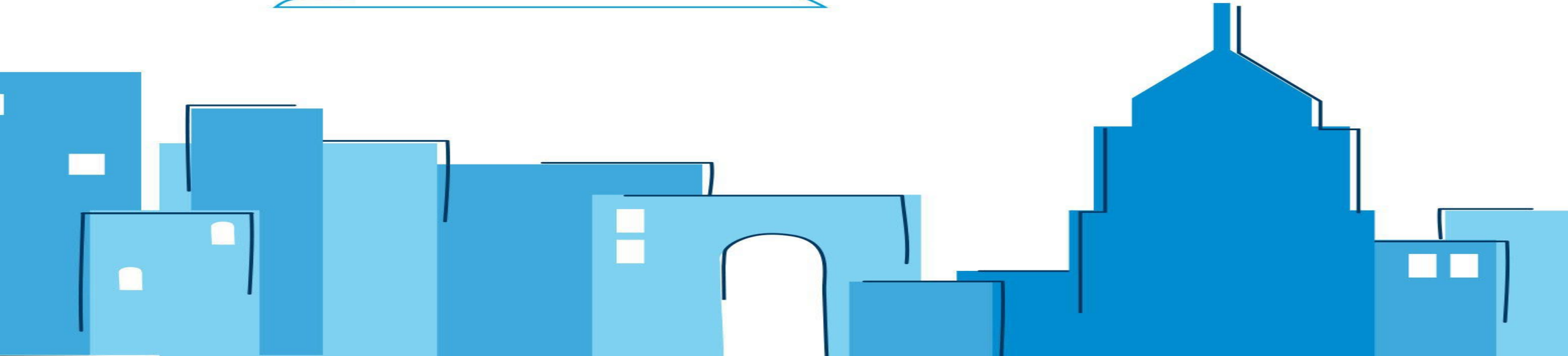


Home / Latest Updates   SEPA Provider Information    PRINT

## Welcome Highmark Blue Shield Providers of Southeastern Pennsylvania

Last Updated: Sunday, March 03, 2024

# Questions?



# Appendix



# Retrospective Authorizations FAQs

## Retrospective Authorization Reviews & Appeals:

Retrospective Authorizations can be pursued within 180 days of date of service unless member benefits define otherwise

Appeals on denied authorizations can be pursued within 180 days of the authorization denial unless member benefits define otherwise

Peer-to-Peer reviews can be completed on any denied appeal, as long as the member's benefits include Peer-to-Peer process

Investigational/Experimental Services\* are eligible for any retrospective review and appeal: **Highmark Medical Review, P.O. Box 890392, Camp Hill, PA 17089-0392**

Non-covered benefits are not eligible for provider appeal or Peer-to-Peer reviews, members maintain the right to appeal

# How to e-Subscribe

Go to "Newsletters/Notices"

The screenshot shows the Highmark website header. At the top right, there are navigation tabs: Medicare, For Members, For Employers, and For Brokers. Below these, there are links: Contact Us, Join Our Mailing List, and Highmark Blue Shield (CPA/SEPA). The 'Join Our Mailing List' link is circled in red, and a red arrow points from the text 'Go to "Newsletters/Notices"' to it. Below the header is a search bar with the text 'Search Keyword or Code' and a blue 'SEARCH' button. The main content area features a large image of two women embracing. On the left, the text reads: 'Welcome to the Highmark Provider Resource Center. Join our network - get credentialed to serve our members.' Below this is a blue 'GET STARTED' button. At the bottom, there is a dark blue footer with icons and labels for: AVAILITY, FEE SCHEDULE, FIND A FORM, PRIOR AUTH LISTS, PROVIDER MANUAL, and SELF-SERVICE HUB. A vertical 'Give Feedback' button is on the right side of the main content area.

# SSO Guide

## Axial

[axialHealthcare Substance Use Risk and Recovery Programs](#)

## Provider Facing Analytics

## Cash Management

[Highmark Provider Manual](#) Section 6.7

## Provider File Management

[Provider Data Accuracy Compliance](#)

## COB Questionnaire

[Highmark Provider Manual](#) Section 6.6

## Provider Resource Center

<https://providers.highmark.com>

## Cover My Meds

## Free Market Health

[Free Market Health](#)

# Behavioral Health

## Care Management

### Utilization Management

Initial, concurrent review and retrospective reviews using the following resources:

- Milliman Care Guidelines (MCG) for psychiatric
- American Society of Addiction Medicine, ASAM (substance use disorder)
- Medical Policy

Supported by a team of medical directors (psychiatrists) who determine medical necessity when Care Management is unable to approve a requested service

Services subject to initial review and concurrent review:

- Inpatient psychiatric/SUD
- Residential psychiatric/SUD
- Additional services are subject to prior authorization and concurrent review based on specific ASO client preferences and expectations (i.e., ABA, PHP, IOP).
- Initial review is suspended when individual states mandate specific prior/initial authorization expectations or suspension of prior/initial authorization.

# Behavioral Health

## *Case Management*

### Behavioral Health Case Management programs:

- Transition of Care
- Depression
- Complex Case Management
- Substance Use Disorder
- Behavioral High Acuity Team (BHAT) (for targeted products)
  - Members with a chronic physical health condition as well as co-occurring SUD or depression
  - Serious Mental Illness (SMI)
- Pediatric

# SEPA Region Facility Claims NAIC Codes

The chart below outlines the appropriate use of NAIC codes for providers in the SEPA region.

Southeastern Pennsylvania (SEPA)		
NAIC Code	Provider Type	Products
15460	All Provider Types	All Highmark <b>Medicare Advantage</b> products
54771S	Facility Type Providers (UB-04/837I)	All Highmark <b>commercial products</b> ; All BlueCard products including Advantage claims for <u>any other</u> Blue Plan.
54771	All Other Provider Types (1500/837P)	All Highmark <b>commercial products</b> ; All BlueCard products including Medicare Advantage claims for <u>any other</u> Blue Plan.

To avoid claim rejections, ensure you or your Trading Partner (Clearinghouse, Vendor, or Billing Service) are submitting claims using the correct NAIC code. If your Trading Partner has questions about this change, they can call EDI Operations at **1-800-992-0246**.

# Highmark Plan Codes

[How to locate the Plan Code on the Member ID: Highmark Sample ID Cards](#)

Plan Code	Location
376 377	SEPA
363 364 378 865	Non-SEPA Pennsylvania
070 570	Delaware
278 379	New York
443 943 944	West Virginia

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