PROVIDER UPDATE

Claims Submission Process for Highmark Health Options Duals (HMO SNP) Highly Integrated Dual Eligible (HIDE) Member: Effective 1/1/2026.

This document details the updated claim submission process for Highly Integrated Dual Eligible (HIDE) members. These members receive both Medicare and Medicaid coverage through Highmark Blue Cross Blue Shield.

Effective January 1, 2026, Highmark will operate as an aligned HIDE plan, necessitating an integrated claims decision across both benefit types. To facilitate integrated claims processing, changes have been made to the current claim submission procedures.

Please review the following instructions and the Frequently Asked Questions (FAQs) thoroughly to prevent any disruption in claim payments.

Effective January 1, 2026:

To process claims for **aligned members**, providers need only submit **a single claim** to the D-SNP Medicare Payer ID (47183), including the D-SNP Medicare ID number. Highmark will automatically process claims under both Medicare and Medicaid benefits, eliminating the need for providers to submit separate claims.

Important: Date of Service Matters:

- **Institutional Inpatient:** Only claims with an admittance date 1/1/2026 or after will be processed under both eligibilities. If admittance date is prior to 1/1/2026. provider is to follow standard process of submitting claim to D-SNP Medicare and then billing Medicaid with EOB.

- **Institutional Outpatient & Professional**: Claims will only process under D-SNP Medicare and Medicaid eligibilities if all lines of claims have a date of service 1/1/2026 or after. If there are any claim lines that are prior to 1/1/2026 DOS provider is to follow standard process and bill Medicare and then bill Medicaid with EOB.

Frequently asked questions

Q1: What if a provider accidentally sends a claim to Medicaid first?
A1: The claim will be denied. Send it to D-SNP Medicare first!

Q2: What if the service is usually paid by Medicaid as the primary payer?
A2: Send claims to D-SNP Medicare first even if it is a Medicaid only code. This includes LTSS and HBCS, please submit to Medicare first.

Q3: What if I only bill for Medicare-covered codes?
A3: If procedure code used to drive payment is different under Medicare vs Medicaid. The claim must include all relevant Medicare and Medicaid codes on the initial Medicare claim. Do not use type of bill XX0.

Q4: What about corrected claims?
A4: If corrected claim is submitted to D-SNP Medicare: The corrected claim will automatically be sent to Medicaid as well. If corrected submitted to Medicaid: The correction will only apply to the Medicaid claim.

Q5: Will *all* D-SNP Medicare claims be processed under Medicaid?
A5: Rejected claims and claims that cannot be processed under D-SNP Medicare for invalid member id or member unable to be located with information billed will not be processed under Medicaid. These claims will require a corrected claim under D-SNP Medicare.

Q6: How does checking claim status (277 transaction) work?
A6: The system works the same way. Use the member's D-SNP Medicare or Medicaid ID to check the status of that specific claim. No change to how you check claim status.

Q7: How will I get paid (835 transaction)?
A7: Providers will continue to receive two separate payments and remittance advises (835s) – one for the Medicare claim and one for the Medicaid claim.

Have questions? Call Provider Services at 1-855-401-8251, Monday – Friday, 8 a.m. – 5 p.m.