SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS **May 01, 2019**

HIGHMARK'S POLICIES CORRECT CODING GUIDELINES BEING ENFORCED THROUGH PENDING CLAIMS AND MEDICAL RECORDS REVIEW EFFECTIVE JUNE 1, 2019

Just as you do everything in your power to deliver the best care for patients, we do everything in ours to ensure practices and hospitals are accurately reimbursed for that care. That's why we have a variety of programs dedicated to ensuring all claims are accurate and appropriate.

To this end, we are implementing a more thorough medical review process for claims that are not coded correctly prior to finalization. Claims will be flagged based on analytics that will enforce existing Highmark Reimbursement and Medical policies that are aligned to the Center of Medicare and Medicaid Services (CMS) coding policies and nationally medically accepted standards. Furthermore, accuracy in coding is important in providing accurate compensation for services provided by physicians.

Highmark is committed to providing transparency as new analytics emerge, and expect to reinforce key guidelines on a monthly cycle. Details around these guidelines will be shared through an eBulletin on the Provider Resource Center 30 days in advance of the analytic going live.

ANALYTICS BEING IMPLEMENTED NEXT MONTH

Effective **June 1, 2019**, we will be implementing analytics to reinforce the following Reimbursement and/or Medical Policies

- RP-005: Modifiers 54 and 55
    - This policy addresses the indications and limitations of co-management of surgical procedures that carry a 10 or 90 day global period. It also provides guidelines for proper billing and documentation. Management of a surgical procedure is the primary responsibility of the operating surgeon.
    - Physicians who perform surgery, and furnish all the usual pre and post-operative work should bill for global surgical care using the proper CPT surgical code(s).
    - Physicians should not bill separately for visits or other services that are included in the global package.

    - Occasionally, a physician must transfer the care of the patient during the global period. In these instances, modifier 54 and 55 are used to distinguish who is providing care for the patient.
- RP:035: Correct Coding Guidelines
    - This policy outlines the systems and sources of coding information used to appropriately adjudicate claims and addresses:
        - Medically unlikely situations, such as two conditions that cannot occur together.
        - Similar codes which may be clinically duplicative which occur on the same day.
        - Appropriate use of codes which represent a combination of two or more components.

REVIEW PROCESS BASICS

We are implementing this review process to help avoid adjusting claims and retracting payments. The goal is to ensure that the claim is coded correctly and supported by medical record documentation, the review process is not based on medical necessity or appropriateness.

This review process will be completed in accordance with:

- All applicable Highmark medical and reimbursement policies
- Centers for Medicare & Medicaid Services (CMS) medical coding policies
- Local and regional Medicare policies and standard practices utilized nationally

You will be notified by letter when additional information is needed to finalize the claim. Once receiving a notification:

- **You must return the information within 30 days to ensure prompt processing of the claim**.
- **Claims or services will be denied when records are requested but not received**.
- You will be notified via letter for all claims denied following a medical records review.

WHAT THIS MEANS FOR PROVIDERS

The medical record review process will have little impact your current practices.

You will:

- Continue to submit claims according to current Highmark, CMS, and accepted regional coding policy
- Look for correspondence that may be requesting medical records
- Return all requested information to the address provided

APPEALS

If you disagree with the denial of your claim(s), you may appeal the decision.

- Standard appeal rights will apply
- Submit your appeal to Highmark using the addresses included in your denial letter

It is imperative that you provide documentation or an explanation specific to the reason for the denial in order for the claim to be reconsidered.

REVIEW HIGHMARK'S REIMBURSEMENT AND MEDICAL POLICIES

Highmark's Reimbursement and Medical Policies are available for your review on the Provider Resource Center. As new policies are developed, they will be added to the Resource Center. Please check this page regularly for the latest updates.

To access the Reimbursement policies:

- Go to the **Provider Resource Center**
- Click the plus sign (+) next to **CLAIMS, PAYMENT & REIMBURSEMENT**
- Select **Reimbursement Policy**

To access the Medical Policies:

- Go to the **Provider Resource Center**
- Click **Medical Policy Search** in the top banner
- Select **Medical Policies**
- Enter the policy you are searching for into the **Search Bar**

MORE INFORMATION

For additional information, watch the Provider Resource Center for updates on Highmark's new medical records review process.

Thank you for your continued assistance in ensuring that Highmark members receive necessary services in a high-quality, clinically appropriate fashion. We appreciate your support and the care you provide to our members, your patients.