NEWS FOR ALL PROVIDER TYPES

HIGHMARK ADDING COMMERCIAL PRODUCTS TO ENHANCED CLINICAL EDITING PROCESS 3/6/17

As indicated in November 2016, Highmark introduced enhancements to our claims editing processes to promote correct coding. At the time it was limited to claims submitted for members of Highmark's Medicare Advantage products* and for members who purchased our Affordable Care Act (ACA) products on the federal health insurance exchange. The November announcement was a clarification of the originally published announcement of these edits on June 28, 2016. Beginning March 6, 2017, Highmark will expand those edits to our Commercial products*.

*Group benefits may vary. Always check NaviNet Eligibility & Benefits to verify coverage prior to providing services.

As indicated in our June 28, 2016 announcement, Highmark implemented up-front enhancements to our clinical editing processes and information systems that promote correct coding. To reiterate, the enhancements take into consideration Highmark's historical claims experience and policy guidelines from the following sources:

- Centers for Medicare & Medicaid Services (CMS) medical coding policies
- American Medical Association (AMA) Current Procedural Terminology (CPT®) coding guidelines
- Local and regional Medicare policies

Highmark's payment policies focus on areas such as:

- National bundling edits, including the Correct Coding Initiative (CCI)
- Modifier usage
- Global surgery period
- Add-on code usage
- Age/gender appropriateness
- CMS National Coverage Determinations

Claims Adjustments and Appeals

Based on this new clinical claim editing process, your payment may be adjusted if the information submitted on your claim isn't supported by the recognized policy sources, including the requirements of CMS, the AMA, other specialty academies' policies and procedures and Highmark's plan-specific requirements.

We recognize that there may be times when the services for which you bill may differ from our medical and claims payment policies. If you don't agree with the payment decision, you have the right to appeal the determination. Clear documentation of the patient's condition must be detailed in the medical record and in the current treatment plan. Please refer to the *Highmark Blue Shield Office Manual* or the *Highmark Facility Manual* (both of which are available on our Provider Resource Center) for specific actions that are required to appeal a claims payment decision.

Including the supporting patient documentation (i.e., medical records and treatment plans) is imperative to having a claim reconsidered for payment. Without such documentation, the claim cannot be reconsidered. Please see the above-noted provider manuals or call Provider Service if you have specific questions regarding the appeals process.

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Important Notes

- Expansion to Commercial will begin for any claims processed on March 6, 2017, and later.
- These policies will apply to professional and facility claims.
- There are no changes to any processes, including claims submission, customer service and support, or grievances and appeals.

WHAT THIS MEANS TO YOU

Please distribute this important information to the claims/coding staff members at your practice or facility. As a reminder, claims for Highmark members should be submitted with the appropriate coding and should be coded to the highest level of specificity, using the correct modifiers and diagnosis and procedure codes.

For complete details on the enhanced clinical editing process, see the NaviNet® Plan Central message dated June, 28, 2016, or the story featured in Issue 4, 2016, of *Provider News*.

Highmark is also expanding the clinical editing process to certain injectable and biological drugs, effective April 1, 2017. See NaviNet message posted on Feb. 1, 2017, for details.

*Highmark's Medicare Advantage products aren't available in Delaware.