SPECIAL eBULLETIN

FOR FACILITY PROVIDERS **October 28, 2019**

HIGHMARK'S POLICIES CORRECT CODING GUIDELINES BEING ENFORCED THROUGH PENDING CLAIMS AND ITEMIZED BILL REVIEW

Highmark is continuing targeted efforts to ensure claims are billed correctly and paid appropriately the first time around. Building upon the recently implemented medical records reviews for pending claims in June of this year, we are expanding those reviews to include itemized bills. This is another program dedicated to ensuring all claims are accurate and appropriate.

We have implemented a more thorough itemized bill review process for claims that are not coded correctly prior to finalization. These more thorough reviews 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 reviews and requests for documentation are required. While a more thorough review is underway, process basics remain the same and are articulated below for clarity.

REMINDER: REVIEW PROCESS BASICS

We implemented 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 itemized bill documentation. This review process is not based on medical necessity or appropriateness.

This review process is being 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 phone or letter when additional information is needed to finalize the claim. Once receiving a notification:

- **You must return the information within 5 days to ensure prompt processing of the claim.**
- **Claims or services will be denied when an itemized bill is requested but not received.**

WHAT THIS MEANS FOR YOU

The itemized bill review process will have little impact on 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 an itemized bill
- Return all requested information based on the instructions provided

APPEALS

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

- Standard appeal rights will apply
- Contact Provider Service if you need additional information prior to submitting your appeal

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 Provider 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.

NOTE: This was updated from a Professional and Facility Provider bulletin to a Facility bulletin only on October 28, 2019.