SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS

February 14, 2020

PREPAY CLINICAL VALIDATION PROGRAM

Just as you do everything in your power to deliver the best care for patients, at Highmark 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 clinically appropriate.

To confirm all providers are adhering to Highmark payment policy and correct coding standards, starting **Quarter 2, 2020** Highmark's Prepay Clinical Validation Program will have a team of Registered Nurses and Certified Professional Coders regularly reviewing individual professional and outpatient claims. This program will validate that coding is correct for the patient on the specified date of service that the service is performed on the date listed on the claim.

ACCURATE CODING REVIEW

This initiative will affect all claims that use a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Below are some coding reviews that the Prepay Clinical Validation Program will consider. If you submit a claim with one or more of these codes, the claim may be sent to Clinical Validation and potentially denied at the line level in accordance with Highmark payment policies and the Highmark Provider Manual.

- When you have a primary code rejected by another Clinical Validation edit
- When you pair a Corrective Coding Initiative (CCI) code with a GB modifier indicator of 1 and submit the claim with a CCI approved modifier
  NOTE: In this case, the code with the lower RVU will be flagged for review
- When you submit two or more evaluation and management (E/M) codes for the same patient
- When you submit an E/M component code with a modifier of 57, 25, 24, 58, 78, or 79 for a patient one day prior to their major surgery during their preoperative period
- When you submit multiple claims with codes that have the same or similar anatomic modifiers

CODING REVIEW OUTCOME

As always, claims with correct coding will be paid as usual. If claims don't pass the accurate coding review, you will receive notice of any denied claim lines within normal business processing timeframes on your Explanation of Payment (EOP). If your claim is denied, you may request an appeal by following the guidelines provided in Chapter 5, Unit 5: Denials, Grievances & Appeals of the **Highmark Provider Manual**.

To access the manual:

- Go to the **Provider Resource Center**
- Click **Manuals** on the top navigation bar
- Select **Highmark Provider Manual**
- Scroll down to **Chapter 5 Unit 5**