

# Special Bulletin

For facility providers

April 28, 2023

## New Start Date for Emergency Department Room Claim Audits

Effective **September 1, 2023**, Highmark will begin auditing outpatient Emergency Department facility claims to ensure the correct procedure codes are being billed.

Originally, audits were to begin on May 1, 2023. However, due to additional updates to [Reimbursement Policy \(RP\)-037: Emergency Evaluation and Management Coding Guidelines](#), the effective date for the audits has been moved until **September 1, 2023**.

These audits are designed to determine the appropriate and fair level of facility reimbursement for emergency department services based on the Centers for Medicare and Medicaid Services (CMS) criteria for the appropriate procedure code. Highmark will review the diagnoses submitted as well as the services performed to ascertain the appropriate level of care for the visit on a scale of one (1) through five (5).

The auditing process may result in a different reimbursement than expected, with Highmark updating the procedure code listed on the claim to the correct procedure code.

On **May 1, 2023**, Highmark will update and republish [RP-037](#) with a full description of these changes.

### How to Determine If Your Claim Was Changed

If the audit determines your claim warrants the level of care at which the claim was billed, the claim will not be changed. If we determine the claim warrants a different level of care, Highmark will add a new line with the correct procedure code and reimburse you at the updated rate.

If Highmark lowers your level of care, you will be able to see the new procedure code on the Explanation of Benefits (EOB). The code you originally submitted on the claim and the code Highmark added to the claim will be stored in our systems for CMS audits. However, the EOB will only show the corrected procedure code.

To view EOBs via [NaviNet®](#), select **AR Management** from the left menu and then click **EOB and Remittance** from the fly-out menu.



## Appealing the Updated Rate

If you disagree with the level of care that Highmark determined through the audit, you can file an appeal with Highmark. To appeal, you will need to submit all related medical records to Highmark's Medical Review team as outlined in *Highmark Provider Manual* Chapter 5, Unit 5: Denials, Grievances & Appeals.

To locate the *Highmark Provider Manual*, hover over **MANUALS** in the quick access bar at the top of the Provider Resource Center and select **HIGHMARK PROVIDER MANUAL**.

This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware, and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health insurance companies.

