Special Bulletin

For professional and facility providers **October 2, 2023**

FEP Claims Will Be Reviewed by Clinical Editing Tool Starting January 1, 2024

To align with our internal claim review process, Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) will start using a clinical editing tool to analyze Federal Employee Program (FEP) claims, effective **January 1, 2024**. Clinical editing is an effective and efficient method for quickly reviewing and approving correct claims, while also identifying errors on incorrectly coded claims during the prepayment process.

Standardizing the Claim Review Process

Our goal is to standardize the claim review process across all lines of business. The benefits of implementing clinical editing on FEP claims include:

- Faster review and approval for correct FEP claims
- Coding inaccuracies will be caught sooner, reducing claims adjustments and provider refunds to Highmark
- Decreased administrative time for researching and adjusting claims that have already been processed and paid
- Consistency of the claim review process for Commercial, Medicare Advantage (MA), and FEP submitted claims

Guidelines and Payment Policies

This enhancement to the FEP claims process takes into consideration Highmark BCBSWNY'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 BCBSWNY'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

With the implementation of the clinical editing tool during the claim review 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, 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.

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.

For more information on the claim appeal process, please refer to **Chapter 5, Unit 5** of the ***Highmark Provider Manual***.