Special Bulletin

For facility providers **October 11, 2024**

Reminder: Emergency Department Claim Audits Using CMS Criteria

Effective Sept. 1, 2023, Highmark began auditing all outpatient Emergency Department facility claims to ensure the correct procedure codes are being billed. 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 reviews the diagnoses submitted as well as the services performed to ascertain the appropriate level of care for the visit on a scale of one through five. 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. Please refer to **Reimbursement Policy (RP)-037: Emergency Evaluation and Management Coding Guidelines** for additional details regarding the tool utilized in the coding analysis.

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 your 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, your EOB will only show the corrected procedure code. To view your EOB via Availity®, choose **Claims & Payments** from the top menu bar and then click on **Remittance Viewer** from the dropdown**.**

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 the *Highmark Provider Manual*: **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals**.