Anthem Blue Cross and Blue Shield
Commercial Facility Reimbursement Policy

Subject: Claims Requiring Additional Documentation		
CO Policy: C-16002	**Committee Approved: 11/16/2018**	**Effective: 07/13/2018**

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products on the date of service and policy criteria listed below.

Description

There may be times when Anthem conducts claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the patient's plan of treatment or to confirm that charges were accurately reported in compliance with the Anthem's policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records. Anthem may accept additional documentation from the facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies, facility's established internal policies, professional licensure standards that reference standards of care, or business practices justifying the healthcare service or supply. The Facility must review, approve and document all such internal policies and procedures as required by The Joint Commission ("TJC") or other applicable accreditation bodies and such policies shall be made available for review by the auditor.

This policy documents the Anthem's guidelines for claims requiring additional documentation and the facility's compliance for the provision of requested documentation.

Policy

Upon request from Anthem or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

- Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
- Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
- Claims with unlisted or miscellaneous codes
- Claims for services requiring clinical review
- Claims for services found to possibly conflict with covered benefits for covered persons after validity review of the member's medical records
- Claims for services found to possibly conflict with medical necessity of covered benefits for covered persons
- Claims requesting an extension of benefits
- Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks
- Claims for services that require an invoice
- Claims for services that require an itemized bill
- Claims for beneficiaries where other health insurance (OHI) is indicated with the claim submission

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- Claims requiring documentation of the receipt of an informed consent form
- Claims requiring a certificate of medical necessity
- Appealed claims where supporting documentation may be necessary for determination of payment
- Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
- Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

Anthem will use the following guidelines for records requests and the adjudication of claims identified for post payment audit:

- Inpatient stay claims reimbursed at a percent of charge with billed charges above $40,000 require an itemized bill to be submitted with the claim.
- Upon confirmation of the facility's address, an original letter of request for supporting documentation will be sent.
- When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
- When a response is not received within 15 days of date of the second request, a final request letter will be sent.
- When a response is not received within 15 days of the date of the final request (60 days total):
    - Anthem will initiate claim retractions for claims identified as post payment audit claims as the facility failed to submit the required documentation. The member shall be held harmless for such payment retractions.

Anthem allows 90 days from the initial request, for records requests and the adjudication of claims identified for prepayment review. When a response is not received within 90 days, Anthem will initiate claim denial for claims identified as pre-payment review claims as the facility failed to submit the required documentation. The member shall be held harmless for such payment denials.

Payment may be denied or recouped when the facility fails to submit required or requested documentation for claims identified for prepayment or post payment audit. When payment is denied or recouped, Anthem will not be liable for interest or penalties.

This policy will not supersede any individual facility contract provisions or state or federal guidelines.

Policy History	
07/13/2018	Committee Date 11/16/2018: • Biennial review; minor language updates. • Policy number updated.
07/13/2018	New requirement language added: Inpatient stay claims reimbursed at a percent of charge with billed charges above $40,000 require an itemized bill to be submitted with the claim.
01/01/2017	New policy adopted.

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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