Commercial Reimbursement Policy

Subject: **Claims Requiring Additional Documentation**	
Policy Number: **C-16002**	Policy Section: **Facilities**
Last Approval Date: **11/05/18**	Effective Date: **01/01/19**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross and Blue Shield (Anthem) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy to the website.

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:

- Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment
- Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill 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
- 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 prepayment review:

- 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.
    - 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 prepayment denials.

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

- 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.

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.

Related Coding

Code	Description	Comment
N/A	N/A	Standard correct coding applies.

Exemptions

Colorado	Effective 01/26/18: Allows 90 days from the initial request, for prepayment review records submission.

Policy History

06/01/2019	New template update
11/05/18	Biennial Review approved: Policy Template updated to separate prepayment review and post payment audit language; GA exemption for removed and requires itemized bills for claims with billed charges above $40,000 for prepayment review effective 01/01/19
01/26/18	Policy language update with prepayment review requirement of itemized bill for claims with billed charges above $40,000.
07/13/16	Initial approval and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- The Joint Commission (TJC)
- The Centers for Medicare and Medicaid Services (CMS)

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

None

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.