

Commercial Reimbursement Policy	
Subject: Claims Requiring Additional Documentation – Professional & Facility	
Policy Number: <b>C-22001</b>	Policy Section: Administration
Last Approval Date: 03/23/2022	Effective Date: <b>03/23/2022</b>

### 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. Our policies apply to both participating and non-participating professionals and facilities as indicated.

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These policies may be superseded by provider or state contract language, or state, federal requirements or mandates.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 these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

### **Policy**

The Health Plan requires professional and facility providers to submit additional documentation for adjudication of applicable types of claims. If the required documentation is not submitted, the claim may be denied.

## Applicable types of claims include:

- 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

Policy# C-22001 Commercial Reimbursement Policy Claims Requiring Additional Documentation Page 1 of 3 Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.



- 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
- Upon request, claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health and Rehabilitation Therapies
- 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

The Health Plan may request additional documentation or notify the provider or facility of additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, we may:

- Deny the claim, as the provider failed to provide required prepayment documentation
- Recover and/or recoup monies previously paid on the claim, as the provider failed to provide required documentation for post payment review

The Health Plan is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

# Related Coding Standard Correct Coding applies

I	Exemptions		
	There are no exemptions to this policy.		

Policy History	
03/23/2022	Initial committee approval and effective 03/23/2022: Claims Requiring Additional
	Documentation-Professional C-16001 and Claims Requiring Additional
	Documentation - Facility C-16002 will be retired and combined into a new blended
	policy titled Claims Requiring Additional Documentation – Professional &
	Facility. Colorado exemption removed effective 03/23/2022 for documentation
	submission for prepayment review.

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### **References and Research Materials**

This policy has been developed through consideration of the following:

- The Joint Commission (TJC)
- 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.

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