Reimbursement Policy	
Subject: **Claims Requiring Additional Documentation**	
Policy Number: **G-06031**	Policy Section: **Administration**
Last Approval Date: **06/02/2022**	Effective Date: **06/02/2022**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ny**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the member's 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. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage strives to minimize delays in policy

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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. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem Medicare Advantage 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.
- Claims for services that require an invoice.
- Claims for services that require an itemized bill.
- Claims for beneficiaries with Other Health Insurance (OHI).
- 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 the Centers for Medicare & 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.

Note: Itemized bills must be submitted with the appropriate revenue code for each individual charge.

Anthem Medicare Advantage 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.

Anthem Medicare Advantage 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

Policy History	
06/02/2022	Biennial review approved: minor language changes: policy template updated
10/26/2017	Review approved and effective 03/01/2019: policy language updated
05/01/2017	Biennial review approved: policy language updated
04/27/2015	Biennial review approved: Policy language updated: policy template updated
01/01/2015	Initial review approved and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Abortion (Termination of Pregnancy)
Claims Timely Filing
Documentation Standards for Episodes of Care
Hysterectomy
Sterilization
Unlisted, Unspecified or Miscellaneous Codes