Commercial Reimbursement Policy

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

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These policies may be superseded by provider or state contract language, or state, federal requirements or mandates.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

- 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

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.

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.