	Reimbursement Policy

Subject: Claims Requiring Additional Documentation

Effective Date:	Committee Approval Obtained:	Section:
07/01/19	**10/26/17**	**Administration**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.healthybluela.com**. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana 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 CPT codes, 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 nonparticipating providers and facilities.

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

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

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Healthy Blue requires professional providers and facilities 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: • Upon request, claims for durable medical equipment; prosthetics; orthotics and supplies; and home health and rehabilitation therapies. • 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 under review 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. • 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 CMS and state or federal regulation. **Note:** Itemized bills must be submitted with the appropriate revenue code for each individual charge. Healthy Blue 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 postpayment review. Healthy Blue is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.
History	• Review approved **10/26/17** and effective **07/01/19**: Policy language updated • Policy template updated **09/01/17** • Biennial review approved **04/27/15**: Policy language updated; Policy template updated • Effective **11/17/14**: Policy language updated • Biennial review approved **05/06/13** and effective **05/06/13**: Disclaimer updated • Review approved **03/12/12** and effective **07/19/10**: Policy template updated

	• Review approved **02/14/11**: Policy language updated; Policy template updated • Review approved and effective **07/19/10**: Payment recoupment added; inconsistent billing/coding patterns clarified; Deleted examples in opening paragraph; Subject to contractual obligation added; Policy template updated • Review approved **06/01/09**: Policy language updated • Review approved **03/23/09**: Policy language and policy template updated • Initial approval effective **06/16/06**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Timely Filing • Documentation Standards for Episodes of Care • Unlisted, Unspecified or Miscellaneous Codes
Related Materials	• None