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 our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.healthybluela.com**. ****

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 Healthy Blue Dual Advantage (HMO D-SNP) member's 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 codes are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

Healthy Blue Dual Advantage 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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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 Dual Advantage strives to minimize these variations.

Healthy Blue Dual Advantage 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 our provider website.

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Policy

Healthy Blue Dual 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.

Healthy Blue Dual 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.

Healthy Blue Dual 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
01/01/2020	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Healthy Blue Dual Advantage contract(s)

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