Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Claims Requiring Additional Documentation		
Effective Date: **03/01/19**	Committee Approval Obtained: **10/26/17**	Section: **Administration**

*****The most current version of the 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.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup 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, Amerigroup may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Amerigroup 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	Professional providers and facilities are required 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 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. • 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. Amerigroup 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, Amerigroup 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. Amerigroup is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.
Exemptions	• There are no exemptions to this policy
History	• Review approved 10/26/17 and effective 03/01/19: Policy language updated

	• Biennial review approved 05/01/17: Policy template updated • Biennial review approved 04/27/15: Policy language updated; Policy template updated • Biennial review approved 05/06/13 and effective 05/06/13: Disclaimer Statement updated 02/27/13 • 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: Policy language updated; Policy template updated • Review approved 06/01/09: Policy language updated • Review approved 03/23/09: Policy language updated; Ohio exemption added; 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 • Amerigroup state contracts
Definitions	• **Reimbursement Policy Definitions**
Related Policies	• Abortion (Termination of Pregnancy) • Claims Timely Filing • Documentation Standards for Episodes of Care • Hysterectomy • Sterilization • Unlisted, Unspecified or Miscellaneous Codes
Related Materials	• None