Wellpoint

Massachusetts | Commercial

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 reimbursement 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 Wellpoint 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, Wellpoint may:

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

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

Wellpoint requires professional 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

Wellpoint may request additional documentation or notify the provider 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

Wellpoint is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

NOTE: This policy does not apply to facility providers.

Related Coding

Standard correct coding applies

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.

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- The Joint Commission (TJC)

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

None

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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