Anthem

New York | Medicaid

Reimbursement Policy
Sanctioned Providers

Policy Number: **G-10002**
Policy Section: **Administration**
Last Approval Date: **12/30/2024**
Effective Date: **10/01/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ny**.

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 member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including 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,
we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit nystateofhealth.ny.gov or call 855-355-5777.
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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

The health plan does not allow reimbursement to providers who are excluded or debarred from participation in state and federal healthcare programs. Claims received for services submitted by sanctioned providers as provided herein will be denied unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

The following exclusions apply:

- Hospital, nursing home, or home healthcare provider, payments will be made for up to 30 days after the date of exclusion for clients admitted prior to the exclusion or whose plan of care was implemented prior to the exclusion
- The health plan may pay the first claim(s) submitted by or on behalf of a dispensing provider for care, services, or supplies ordered or prescribed by an excluded person after the date of exclusion and notify the dispensing provider of the exclusion. No payment will be made for any care, services, or supplies ordered or prescribed by an excluded person more than 20 days after the date of a notice of an exclusion to a dispensing provider.

The health plan screens providers through all applicable state and federal exclusion lists. Services rendered, including emergency services, by sanctioned providers will not be allowed for reimbursement.

Related Coding

Standard correct coding applies

Policy History

- **12/30/2024** - Review approved 12/30/2024 and effective 10/01/25: added language for 30-day payment exclusion for hospital, nursing home, or healthcare providers; added 20-day exclusion for the first claim submitted for dispensing provider
- **12/27/2022** - Review approved: policy template updated; removed ‘Reimbursement of and Opt-Out’ from the policy title
- **11/06/2020** — Review approved: no policy language changes
- **10/03/2018** — Review approved: removed duplicative emergent language
- **10/03/2016** — Review approved: policy template updated
- **01/01/2016** — Policy template updated: Medicare opt-out language removed

- **11/09/2015** — Review approved: policy title updated: policy template updated
- **08/18/2014** — Review approved: Medicare opt-out language expanded
- **05/21/2012** — Review approved 05/21/2012 and effective 12/09/2012: Medicare opt-out policy language added
- **10/11/2010** — Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Code of Federal Regulations (CFR)
- Office of Inspector General (OIG)
- Social Security Act
- State contract
- State Medicaid

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Claims Requiring Additional Documentation
- Emergency Services: Non-Participating Providers and Facilities

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