Anthem

California | Anthem Blue Cross | Medi-Cal Managed Care (Medi-Cal)

Reimbursement Policy

Claims Requiring Additional Documentation

Policy Number: **G-06031**
Policy Section: **Administration**
Last Approval Date: **5/6/2025**
Effective Date: **5/6/2025**

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/ca.

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 Procedural 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.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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 requires professional and facility providers to submit additional documentation for adjudication of applicable types of claims unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. 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
- Claims where other documentation is required by CMS and/or state or federal regulation
- Upon request, claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health and Rehabilitation Therapies
- Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment
- Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits or reviews

Note: Itemized bills must be submitted with the appropriate revenue code for each individual charge.

The health plan 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 the 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

The health plan 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

- **05/06/2025 -** Review approved and effective: added applicable claim types:
  - Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment
  - Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits or reviews
- **06/02/2022 -** Review approved: policy template updated
- **10/26/2017 -** Review approved 10/26/2017 and effective 03/01/2019: policy language updated
- **04/03/2017 -** Initial approval 04/03/2017 and effective 10/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

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 or Miscellaneous Codes

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