Post Payment Review

Reimbursement Policy ID: RPC.0072.PA02

Recent review date: 06/2024

Next review date: 06/2026

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses the review of a medical record following reimbursement by AmeriHealth Caritas VIP Care to validate the accuracy of the claim submitted.

Exceptions

N/A

Reimbursement Guidelines

A medical record and/or itemized bill may be requested to validate the accuracy of a submitted claim. The scope of the validation may encompass any or all of the procedures, diagnosis, or diagnosis-related group (DRG)(APR/CMS) billed by the provider. Medical record reviews may also be conducted for reasons that include, but are not limited to:

- Payment for any services that fail to meet recognized standards of care.
- Incorrect billed charges or selection of the wrong code(s) for services or supplies
- Documentation of items or services billed.
- Duplicate charges
- Lack of documentation in the medical record to support the charges billed.
- Documentation of medical necessity to support services or days billed.
- Non-covered services per the member's plan
- Lack of clinical documentation in the medical record to support the condition for which services are billed.
- Unbundling of charges that are not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.

These reviews also confirm that:

- The most appropriate and cost-effective services and supplies were provided.
- The records substantiate the setting or level of service that was provided to the patient.

If medical records are not received within the requested time frame, AmeriHealth Caritas VIP Care may recoup funds from the provider.

Failure to provide the necessary medical records to validate billing creates a presumption that the claim as submitted is not supported by the facility and professional records.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM)
III. International Classification of Diseases, 10th Revision, Procedure Classification System (ICD-10-PCS)
IV. Healthcare Common Procedure Coding System (HCPCS).
V. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf.

Attachments

N/A

Associated Policies

RPC.0049.PA02 Itemized Bill Review

Policy History

06/2024	Reimbursement Policy Committee Approval
06/2024	Annual review- no major changes
04/2024	Revised preamble
08/2023	Removal of policy implemented by [Insert plan name] from Policy History section

01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section