AmeriHealth Caritas Louisiana

Post Payment Review

Reimbursement Policy ID: RPC.0072.2100

Recent review date: 05/2026

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. The health plan 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.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses the review of a medical record following reimbursement by the health plan 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, the health plan 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 Coding System (ICD-10-PCS)
IV. Healthcare Common Procedure Coding System (HCPCS).
V. https://www.amerihealthcaritasla.com/pdf/provider/resources/manual/handbook.pdf

Attachments

N/A

Associated Policies

RPC.0049.2100 Itemized Bill Review

Policy History

10/2026	• Removed the next review date • Replaced the plan name with "the health plan"
05/2026	Reimbursement Policy Committee Approval

05/2026	Biennial review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised Preamble
06/2024	Reimbursement Policy Committee Approval
05/2024	Annual Review • No major changes
04/2024	Revised preamble
12/2023	Reimbursement Policy Committee Approval
	Precedes Act 319