Itemized Bill Submission

Reimbursement Policy

Policy

Community Health Options ("Health Options") requires an itemized bill for each claim with a billed amount equal to and greater than $20,000; an itemized bill may also be requested on claims identified for further review. "An itemized statement is defined as a listing of each service(s) or item(s) provided to the beneficiary. Statements that reflect a grouping of services or items (such as a revenue code) are not considered an itemized statement" (CMS).

The itemized bill must include all the following for each line-item detail (but not limited to):

- charge code
- description
- date of service
- quantity
- charge amount
- CPT/HCPCS code
- modifier (if applicable)

Itemized bills are required to match the associated billed claim form for a thorough claims review process and reimbursement determination.

For your convenience, Health Options accepts itemized bills electronically using the following email address: itemizedbill@healthoptions.org

Claims submitted without the associated itemized bill will be denied for reimbursement.

Related Policies

Facility Revenue Code Requirements
Hospital Outpatient Observation
Interim Billing & Split Claim
Modifier Reference Guide
Routine Supplies, Services, and Medical Equipment
Outpatient & Professional Service Claim Edits
Professional Services
Payment Integrity Audit
Replacement Claim Billing

References / Resources

Centers for Medicare & Medicaid Services, Medicare Program Integrity Manual, Chapter 4, Section 4.20.5.1: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf

Document Publication History

12/28/2021 Annual review: line-item data elements changed from sentence to bullet point format and added Related Policies
11/9/2020 Annual review: Added email address
7/15/2019 Initial publication

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.