Itemized Bill Submission

Reimbursement Policy

Policy

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

Itemized bills must be submitted within 30 days from the date of the request. Claims submitted without the associated itemized bill, within the specified timeframe, will be denied for reimbursement.

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

Related Policies

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

Document Publication History

- 3/07/2023 Annual review: no changes
- 3/15/2022 Added timeframe requirement
- 12/28/2021 Annual review: minor formatting update 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 the underpinning direction stated otherwise.

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