Request for Medical Records

Reimbursement Policy ID: RPC.0083.05xx

Recent review date: 04/2026

Next review date: 07/2028

AmeriHealth Caritas Pennsylvania 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 Pennsylvania 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

The purpose of this policy is to outline the circumstances that may prompt AmeriHealth Caritas Pennsylvania to require that a provider submit medical records to support billed services.

AmeriHealth Caritas Pennsylvania reimbursement policies are intended to help providers in submit accurate claims and to summarize the conditions for reimbursement of services covered by a member's health plan. Claims submitted to AmeriHealth Caritas Pennsylvania must meet published medical necessity and prior authorization requirements; and providers are expected to adhere to industry standard billing and coding guidelines when reporting services, items, and supplies to AmeriHealth Caritas Pennsylvania for reimbursement.

Exceptions

N/A

Reimbursement Guidelines

All services reported to AmeriHealth Caritas Pennsylvania must be supported in the medical record. AmeriHealth Caritas Pennsylvania may request medical records from billing providers when analysis of current and/or historical provider or member claim data suggests the most appropriate code(s) were not selected for billing. Such circumstances include, but are not limited to:

- Reported services that exceed usual and customary service thresholds
    - Critical care services
    - National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) or Medically Unlikely Edits (MUE) modifier overrides
    - Reported units of drugs, devices, supplies, or services that exceed Medically Unlikely Units
    - Excessive billing of Tier 2 molecular pathology codes
    - Unusual superficial/deep implant removals
    - Unlikely frequency of radiation therapy planning and management codes
    - Non-conformance with national industry standard coding guidelines
    - Chiropractic billing of physical medicine modalities and/or manipulation on the same anatomic region during the same episode of care
- Overlapping services for same episode of care
    - Inpatient and outpatient services on the same dates of service (Note: Dates of admission and discharge are excluded.)
    - Home hospice, home health, and/or durable medical equipment services overlapping an inpatient stay
    - Maternity antepartum, delivery, or postpartum services overlapping previously reported maternity services
    - Independent laboratory claims for date of service overlapping an inpatient stay
- Related service(s) not found for same episode of care
    - Add-on code billed without related base code
    - Billed anesthesia service does not correspond to any procedure billed for the member during the same episode of care
    - Discrepancies between facility and professional reporting for same episode of care (e.g., emergency room, inpatient or outpatient facility stay)
- Evaluation and management services
    - New patient evaluation and management service with previous visit within three years
    - Reported by inappropriate provider type
    - Referring provider missing on consultation claim
        - Referring provider is the same as treating provider
        - Services provided to an established patient
    - Critical care services reported in circumstances unlikely to meet coding requirements
        - Critical care patient discharged to home
- Inappropriate or missing modifier
    - Surgical services in place of service 20 or 23
    - Fracture dislocation service in place of service 20 or 23
    - Services billed in place of service 11 with modifier indicating an unplanned return to operating/procedure room
    - Technical component reported by a professional in a facility setting
    - Related services during the global period of a previous surgical procedure
- Standard data elements missing from claim documentation
    - Laboratory services missing referring provider or referring provider is the same as treating provider
    - Laboratory tests unsupported by reported diagnoses

- Potential upcoding, based on peer comparison
    - Consultations
    - Complex cataract surgery
    - Percutaneous nephrolithotomy procedures
    - Musculoskeletal excision procedures
    - Adult, pediatric, or neonatal critical care services
    - Prolonged services

Definitions

Medical records
Medical records are the documents that explain all detail about the patient's history, clinical findings, diagnostic test results, preoperative and postoperative care, the patient's progress, and medications.

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. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding AmeriHealth Caritas Pennsylvania Clinical Policies.
VII. Applicable AmeriHealth Caritas Pennsylvania manual reference.
VIII. Commonwealth of Pennsylvania Medicaid Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

04/2026	Reimbursement Policy Committee Approval
03/2026	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
07/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Pennsylvania 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