AmeriHealth Caritas Pennsylvania

Itemized Bill Review

Reimbursement Policy ID: RPC.0049.05xx

Recent review date: 07/2026

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

Inpatient facility services are reimbursed under a prospective payment system, where the payment amount for a particular service is based on the classification system of that service. In addition to the basic prospective payment, an outlier payment is made for cases that incur costs above the facility-specific threshold.

In accordance with state and federal requirements for government health plans, the health plan administers itemized bill pre and post payment reviews to ensure the accuracy of payments made on inpatient facility claims with cost outliers. The health plan applies the CMS criteria and guidelines, which are the industry-accepted standard, as well as all state-specific requirements for itemized bill review and inpatient facility reimbursement.

Exceptions

N/A

Reimbursement Guidelines

For inpatient facility claims paid under Diagnostic-Related Group (DRG) submitted with cost outliers:

I. The health plan will pend the claim and request an itemized bill from the provider. The request will include instructions on how and by when the itemized bill must be submitted. If the itemized bill is not received from the provider, the health plan will pay base DRG only.

II. The health plan will reconcile charges between the itemized bill and the claim. The claim will be adjusted without an outlier payment for charges that reflect discrepancies between the claim and the itemized bill. These discrepancies include, but are not limited to:
   - Duplicate charging for the same service/supply and unbundling the charge of a service/supply – particularly a routine service/supply – from another service/supply that is already being charged.
   - Providers are also reminded that each hospital operating within the United States is required to establish a list of standard charges for its services/supplies, including those for diagnosis-related groups (DRGs).

III. The health plan will communicate the determination of the itemized bill review to the provider within 30 days of receiving the itemized bill. The communication will include instructions if the provider wishes to dispute or appeal.

Definitions

Cost Outlier
Inpatient services provided during a single visit that have an extraordinarily high cost as established by Medicare are therefore eligible for additional payments above and beyond the base rates of DRG or APR-DRG.

Edit Sources

I. False Claims Act (31 USC §§ 3729-3733).
II. Medicare and Medicaid Program Integrity (42 USC § 455, 42 USC § 420).
III. Affordable Care Act Standard Hospital Charges (42 USC § 300gg-18(e)).
IV. Centers for Medicare and Medicaid Services (CMS) Outlier Payments, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.
V. National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications.
VI. Current Procedural Terminology (CPT) and associated publications and services.
VII. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
VIII. Healthcare Common Procedure Coding System (HCPCS).

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date

	• Replaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
06/2026	Biennial review • Added definition
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
10/2024	Annual review • Updated to Biennial review
04/2024	Revised preamble
12/2023	Reimbursement Policy Committee Approval