Submission of Claims

Reimbursement Policy ID: RPC.0016.5400

Recent review date: 06/2026

Next review date: 07/2028

AmeriHealth Caritas District of Columbia 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 District of Columbia 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, 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 serves as guidance for the submission of claims for processing.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas District of Columbia aligns with the District of Columbia Medicaid program guidelines listed in the Provider Manual regarding processing claims. Reimbursement is based on the provider's contracts, utilizing CPT/HCPCS codes, with a "clean claim" requirement for prompt payments. The Provider Manual lists topics and guidance for the submission of clean claims for reimbursement. Topics include but not limited to:

- Required claim elements for filing
    - Accurate patient and provider information, service details, and supporting medical documentation.
- Claim filing deadlines
    - Typical limits ranging from 90 days to a year. Claims received beyond the timely filing limit will not be reimbursed. Verify the specific guidelines in the AmeriHealth Caritas District of Columbia provider manual.
- Claim forms fields
    - Ensure accurate patient and provider demographics, using correct diagnosis and procedure codes (ICD-10 and CPT), and attaching all required supporting documents like insurance cards and prior authorization numbers.
- Appeals and disputes
    - Deny claims submitted with bill type xx7 if the condition code does not clearly specify the nature of the requested change or adjustment.

Code	Meaning
D0	Change in Service Dates
D1	Change in Charges
D2	Change in Revenue Codes
D3	Change in Diagnosis
D4	Change in Procedure Codes
D7	Change in Patient Status
D8	Change in Diagnosis and Procedure Codes
E0	Change in Patient Status and Diagnosis

- Electronic claims submission
    - Software that meets electronic filing requirements as established by the HIPAA claim standard and by meeting CMS requirements contained in the provider enrollment & certification category area of this web site and the EDI Enrollment page in this section of the web site.
- Submitting corrected claims
    - Wait until all charges are documented before filing the initial claim, adhering to timely filing deadlines for all submissions (including corrections), and only submitting a corrected claim after the original has been processed and a status notification has been received.
- National Correct Coding Initiative (NCCI)
    - Providers must use the appropriate HCPCS/CPT codes and adhere to the NCCI PTP and MUE edit files updated quarterly by the Centers for Medicare & Medicaid Services (CMS).
- ICD-10 Codes
    - Use specific and current ICD-10-CM codes for services, pairing them with the CPT codes that describe and support the services performed.
- Documentation guidelines
    - Require accurate, complete medical records that justify the services billed, along with patient and insurance information, to support the claim's medical necessity and facilitate processing.
- Outpatient and hospital billing

    - Use the appropriate institutional claim form with accurate coding and be submitted within the designated timeframes for the specific payer. Also ensure they submit medically necessary services with relevant diagnosis codes, follow payer-specific coding guidelines, and have accurate documentation to support the services rendered.
- Ancillary services
    - Submit accurate and complete claims with appropriate diagnostic and procedural codes via the UB-04 or CMS-1500 form, or their electronic equivalents. Key requirements often include a valid NPI, correct dates of service, itemized services using specific revenue codes, and the submission of supporting documentation or pre-authorization information, according to various provider manuals.
- Home health
    - Reimbursement requires timely submission of a Notice of Admission (NOA) within five days of the start of care, followed by a claim within one year of service.
- Maternity
    - Providers should bill the appropriate CPT code that describes the type of service (antepartum, delivery, and postpartum care). Please consult the Obstetrics policy for more detailed guidance.
- Durable medical equipment
    - Include a physician's Standard Written Order (SWO) or Written Order for Prior Approval (WOPD), supporting medical records demonstrating medical necessity, and Proof of Delivery (POD). Submit your claim using the appropriate CMS-1500 form (or its electronic equivalent) within the payer's specified deadline.

Although AmeriHealth Caritas AmeriHealth Caritas District of Columbia prefers the submission of claims electronically through the electronic data interchange (EDI), [AmeriHealth Caritas District of Columbia will accept paper claims. A paper claim must be submitted on an original claim form with red ink, computer-printed or typed, and in a large, dark font in order to be read by optical character reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.

All providers must verify member eligibility prior to rendering services to confirm that the member has active and applicable coverage for the services to be provided. Eligibility verification should include confirmation of coverage dates, benefit limitations, and any applicable authorization requirements. Failure to verify eligibility can result in claim denial.

When submitting claims to Medicaid, providers must ensure that all other liable third-party payers have been billed first, as Medicaid is the payer of last resort.

For complete guidelines please see the Claims and Billing section of the AmeriHealth Caritas District of Columbia website: https://www.amerihealthcaritasdc.com/provider/claims/index.aspx.

Definitions

Clean Claim
A request for payment that contains no defects, improprieties, or missing information requiring outside investigation or development that passes all automated system edits and can be adjudicated immediately.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).

VI. AmeriHealth Caritas District of Columbia provider manual.
VII. Applicable District of Columbia Medicaid publications.
VIII. Applicable District of Columbia Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0068.5400 Obstetrics
RPC.0074.5400 Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS)
RPC.0100.5400 Home Health Services
RPC.0122.5400 Corrected Claims

Policy History

06/2026	Reimbursement Policy Committee Approval
05/2026	Biennial Review • Added Associated Policies • Added Clean Claim Definition/Language • Expanded Reimbursement Guidelines Language
06/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia 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