AmeriHealth Caritas Ohio

By-Report Reimbursement

Reimbursement Policy ID: RPC.0095.7700

Recent review date: 10/2025

Next review date: 05/2027

AmeriHealth Caritas Ohio 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 Ohio 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

This policy outlines AmeriHealth Caritas Ohio reimbursement methodology pertaining to By–Report , Priced by Prior Authorization (PA), and Unlisted Codes.

Exceptions

Exceptions pertaining to payment of procedures, services, and supplies include, but are not limited to:

- Procedures, services, and supplies related to immunizations, injections, and infusions (including trigger-point injections), skin substitutions, and provider- administered pharmaceuticals outlined in OAC 5160-4-12.
- Services and/or supply items related to durable medical equipment outlined in OAC 5160-10-01 and OAC 5160-10-16.

Reimbursement Guidelines

Procedures, services, and supplies in which pricing guidelines are not otherwise indicated in relevant rules associated with the payment schedule shall be reviewed manually. The purpose of the review is to determine whether the procedure code for the by-report procedure, service, or supply reported on the claim is the most appropriate. Supporting information must be provided with all claim submissions (e.g., supporting documents such as operative reports, clinical assessments, invoices, or other medical records) to identify the by-report procedure, service, or supply.

By-Report
Claims submitted with procedure code(s) listed with price "BR" (By-Report procedure, service, or supply) are reviewed and may be denied under the following conditions:

- The information submitted on or with the claim does not adequately describe the reported by-report procedure, service, or supply, and additional documentation requested by the reviewer is not supplied; AND/OR
- The procedure, service, or supply corresponds to a more appropriate procedure code with a specified price.

If a claim is denied because a different HCPCS or CPT code better corresponds the actual procedure, service, or supply, the provider may submit a new claim with the appropriate code. The new claim must not be submitted for by-report consideration.

Temporary procedure codes with pricing designated as by-report require review and prior approval. Review and approval are case-specific.

If claim coding is deemed appropriate, payment methodology will be:

- 25% (twenty-five percent) of provider billed charges as configured within the payment system, or
- As stipulated in the provider's Single Case Agreement (SCA).

Priced/Determined by Prior Authorization
For items priced by Prior Authorization (PA), the relevant payment amount is determined per the following in the following list:

- Supply items – 147% (one hundred forty-seven percent) of provider cost;
- Wheelchairs, wheelchair components/accessories, standing frames, gait trainers, and other DMEPOS Complex Rehabilitation Technology (CRT) equipment and supplies – 120% (one hundred twenty percent) of the base invoice charges;
- Enteral Nutrition Products – 185% (one hundred eighty-five percent) of provider cost; and
- Other non-supply DMEPOS items or services – Amount will be determined on a case-by-case basis.

Definitions

Category III CPT Codes
Temporary codes for emerging technology, services, procedures, and service paradigms.

By-Report Codes
These codes identify a covered procedure, service, or supply for which no single maximum payment amount has been established and for which payment is not determined by prior authorization.

Prior Authorization (PA) Codes
These codes identify a covered procedure, service, or supply for which no single maximum payment amount has been established and for which payment is determined by prior authorization.

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. https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-60.4.
VII. https://codes.ohio.gov/ohio-administrative-code/rule-5160-4-12.
VIII. https://codes.ohio.gov/ohio-administrative-code/chapter-5160-10.
IX. Ohio Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

10/2025	Reimbursement Policy Committee Approval
08/2025	Annual Review • Wording adjustments for clarity. • No major content change.
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Ohio 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