



## Reimbursement Policy

**Subject: Eligible Billed Charges**

Effective Date: <b>08/24/18</b>	Committee Approval Obtained: <b>05/27/20</b>	Section: <b>Administration</b>
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\*\*\*\*\*The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com/TX>. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.\*\*\*\*\*

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

<b>Policy</b>	Eligible charges means charges billed by the provider subject to conditions and requirements which make the service eligible for reimbursement. Amerigroup allows reimbursement of eligible charges unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Eligibility for reimbursement of the billed service is
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	<p>dependent upon application of the following conditions and requirements:</p> <ul style="list-style-type: none"> <li>• Member program eligibility</li> <li>• Provider program eligibility</li> <li>• Benefit coverage</li> <li>• Authorization requirements</li> <li>• Provider manual guidelines</li> <li>• Amerigroup administrative policies</li> <li>• Amerigroup clinical policies</li> <li>• Amerigroup reimbursement policies</li> <li>• Code editing logic</li> </ul> <p>The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, copayments, deductibles and coordination of benefits.</p> <p>Amerigroup will not reimburse providers for:</p> <ul style="list-style-type: none"> <li>• Items the provider receives free of charge.</li> <li>• Items the provider provides to the member free of charge .</li> </ul> <p>In absence of clear language or specific reference to eligible charges in provider contracts, the use of the following terms will default to eligible charges as stated within this policy:</p> <ul style="list-style-type: none"> <li>• <i>Billed charges</i></li> <li>• <i>Covered charges</i></li> <li>• <i>Billed charges for covered services</i></li> <li>• <i>Allowed charges</i></li> <li>• <i>Percent of charge</i></li> </ul>
<p><b>History</b></p>	<ul style="list-style-type: none"> <li>• Biennial review approval 05/27/20</li> <li>• Biennial review approved 05/04/18: policy template updated</li> <li>• Biennial review approved 07/14/16: policy template updated</li> <li>• Biennial review approved 08/24/15: policy language reorganized; policy title updated</li> <li>• Biennial review approved 05/20/13: policy template updated</li> <li>• Review approved 04/09/12: background section updated; policy template updated</li> <li>• Review approved 04/11/11: background section updated; policy template updated</li> <li>• Review approved 11/02/09 and effective 04/01/10: allowed amount and default terms for eligible charges clarified, and nonreimbursement for items free of charge added; policy template updated</li> </ul>

	<ul style="list-style-type: none"> <li>• Review approved and effective 02/27/07: policy template updated</li> <li>• Initial approval and effective date: 03/02/06</li> </ul>
<b>References and Research Materials</b>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>• CMS</li> <li>• State Medicaid</li> <li>• Amerigroup state contracts</li> <li>• National Association of Insurance Commissioners (NAIC) Model Regulation, 2013</li> </ul>
<b>Definitions</b>	<ul style="list-style-type: none"> <li>• <b>General Reimbursement Policy Definitions</b></li> </ul>
<b>Related Policies</b>	<ul style="list-style-type: none"> <li>• Claims Submission — Required Information for Professional Providers</li> </ul>
<b>Related Materials</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>