



Reimbursement Policy

Subject: Emergency Services: Nonparticipating Providers and Facilities

Effective Date: **05/01/17**

Committee Approval Obtained:
09/30/19

Section:
Administration

*****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>. Under Quick Tools, select Reimbursement Policies > Medicaid. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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.

Policy

Amerigroup allows reimbursement for emergency services provided by nonparticipating professional providers and facilities unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Unless otherwise required by federal and/or state regulation or contract, reimbursement is based on the following:

- For Medicaid product lines only: State rule as listed in Exhibit A
- For Medicare product lines only: The amount that would have been reimbursed to the provider if the beneficiary were enrolled in original Medicare
- For all other product lines: The applicable out-of-network emergency rate for nonparticipating providers and facilities

Amerigroup adheres to the requirements of the Emergency Medical Treatment and Labor Act and the Federal Medicaid Managed Care Regulations.

Amerigroup will act in accordance with the Deficit Reduction Act (DRA) of 2005, Section 6085, with an effective date of January 1, 2007, that states:

“Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity’s Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a state where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.”

Amerigroup shall develop and maintain a record, pursuant to DRA stipulations, for each market’s payment methodology according to the respective state’s Fee-for-Service Medicaid Program guidance. (See Exhibit A.)

Amerigroup will not limit consideration of reimbursement for emergency services on the basis of lists of diagnoses or symptoms; however, additional medical record documentation may be required in order to clearly identify and determine appropriate reimbursement of emergency services.

Claims for emergency services are subject to the Eligible Billed Charges, Code and Clinical Editing Guidelines, and Claims Requiring Additional Documentation reimbursement policies of Amerigroup.

<p>Exemptions</p>	<ul style="list-style-type: none"> • Amerigroup Community Care in Maryland allows reimbursement to a network group at the participating provider rate for covered services provided by a nonparticipating provider if the provider meets all of the following conditions: <ul style="list-style-type: none"> ○ Is employed by or is a member of the group ○ Has applied for acceptance into the Amerigroup Community Care in Maryland network and has been notified of intent to continue processing the credentialing application ○ Has a valid license to practice in the state of Maryland ○ Is hospital-based and currently credentialed by an accredited hospital in the state of Maryland or has professional liability insurance <p>Note: If the provider’s application is rejected, Amerigroup Community Care in Maryland will reimburse according to policy for covered services provided on or after the date of the rejection notice.</p> <ul style="list-style-type: none"> • Amerigroup Texas, Inc. and Amerigroup Insurance Company may send claims for emergency services from a nonparticipating facility to the Texas Medicaid Healthcare Partnership for pricing to ensure the claim is reimbursed in accordance to the DRA of 2005, Section 6085.
<p>History</p>	<ul style="list-style-type: none"> • Biennial review approved 09/30/19: Tennessee Exhibit A updated • Biennial review approved and effective 05/01/17: Policy template updated; New Jersey exhibit A updated; Exhibit B removed • Effective 12/31/15: Exited Florida Medicare • Biennial review approved 11/09/15: Policy template updated; New Jersey exemption removed and Exhibit A updated; Kansas Exhibit B updated • Effective 01/30/15: Texas exemption updated • Review approved 07/30/14: New Jersey exemption updated; New Mexico removed from Exhibits A and B • Effective 06/01/14: Ohio removed from Exhibits A and B • Effective 12/31/13: Exited New Mexico Medicaid • Biennial review approved and effective 07/29/13: Texas exemption updated • Effective 07/01/13: Exited Ohio • Update due to regulatory directive: New Jersey exemption added 01/23/13; Disclaimer template updated • Review approved and effective 08/27/12: Policy template updated; Kansas, Washington, and Louisiana added to Exhibits A and B

	<ul style="list-style-type: none"> • Biennial review approved 08/15/11: Texas exemption updated; South Carolina exemption removed • Review approved 08/10/09 and effective 10/09/09: Host State versus In-State reimbursement and DRA applicability clarified; Exhibit A and B added; Maryland exemption added; Policy template updated • Initial policy approval and effective date 09/20/06
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • Amerigroup state contracts • DRA of 2005 (Pub. L. No. 109-171) • Emergency Medical Treatment and Labor Act
Definitions	<ul style="list-style-type: none"> • Reimbursement Policy Definitions
Related Policies	<ul style="list-style-type: none"> • Claims Requiring Additional Documentation • Claims Submissions — Required Information for Facilities • Claims Submissions — Required Information for Professional Providers • Code and Clinical Editing Guidelines • Eligible Billed Charges • Sanctioned and Opt-Out Providers
Related Materials	<ul style="list-style-type: none"> • None

Exhibit A: Out-of-State Emergency Market Medicaid Reimbursement

Member state	Professional reimbursement	Facility reimbursement
Georgia	Georgia Medicaid rates	Georgia Medicaid rates
Maryland	Maryland Medicaid rates	Host state Medicaid rates
New Jersey	New Jersey Medicaid rates	New Jersey Medicaid rates
Tennessee	Tennessee state-directed rates	Tennessee state-directed rates
Texas	Texas Medicaid rates	Texas Medicaid rates
Washington	Washington Medicaid rates	Washington Medicaid rates