Reimbursement Policies

We want to assist physicians, facilities and other providers in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup District of Columbia, Inc. benefit plan. Keep in mind that determination of coverage under a member's benefit plan does not necessarily ensure reimbursement. These policies may be superseded by state, federal or CMS requirements. Providers and facilities are required to use industry standard codes for claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The billed code(s) should be fully supported in the medical record and/or office notes. Industry practices are constantly changing and Amerigroup reserves the right to review and revise its policies periodically.

Link: Reimbursement Policy Disclaimer <will link to new page with language below>
Link: General Reimbursement Policy Definitions <will link to new page with language below>

List of category links for policies to be filed under:

Anesthesia
Coding
DME and Supplies
Drugs
Evaluation and Management
Facilities
Medicine
Prevention
Prosthetics and Orthotics
Radiology
Reimbursement Administration — General
Surgery
Transportation

Reimbursement Policy Disclaimer

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 District of Columbia, Inc. 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 District 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 non-participating 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 its policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

General Reimbursement Policy Definitions
These are standard terms used within the majority of our reimbursement policies. For specific policy-related definitions, please view the individual policy. Provider and/or District contract definitions supersede the definitions listed below.

- **Authorization (precertification)**: an approval process for requested medical services, either by a servicing health care provider or the patient, to determine if a request is covered for reimbursement; authorization or precertification is determined by eligibility, plan benefits and medical necessity of the service being requested
- **Benefits**: services covered by an insurance plan
- **Bundled service**: an individual service that is included in a more complex or comprehensive service and billed on the same date of service as the more comprehensive service
- **Code editing logic**: a review and evaluation tool for accuracy and adherence of medical claims to accepted national industry standards, plan benefits and authorization guidelines
- **Code set**: under the Health Insurance Portability and Accountability Act (HIPPA), code sets are any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes
- **Consistency guidelines**: system logic that identifies services that are inconsistent in nature, including:
    - Gender-specific services provided to a member of the opposite sex
    - Age-specific services provided to a member not in the appropriate age range
    - Surgical procedures performed on a member who previously has had the respective organ or only body part of that kind removed
- **Continuity of care**: continuance of care or services rendered by a provider for the purpose of continued treatment due to the complexity or advanced phase of the medical condition for members who are newly enrolled and/or who need to avoid a lapse in care for a medical condition requiring continued care; continuity of care can also be established for existing members who have conditions that require treatment by a provider not currently in, or recently terminated voluntarily from, the network
- **Covered services**: health care services the contractor provides to enrollees, including all services required by contract, District and federal law, and all additional services described by the contractor

- **Encounter:** record of a medically related service (or visit) rendered by a provider to a beneficiary who is enrolled in a participating health plan during the date of service; it includes but is not limited to all services for which the health plan incurred any financial responsibility
- **Episode of care:** a single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition
- **Facility-based provider**: a hospital, nursing home, or other medical or health-related service facility that provides care for the sick, injured or disabled or other care that may be a covered service in an insurance policy
- **Fee schedule**: a list of pre-established allowances for specific services
- **Global allowance**: reimbursement for certain services or surgical procedures that are considered to be directly related to a procedure's global allowance will be considered integral/inclusive to that service and is not allowed separate reimbursement; reimbursement for surgical procedures includes the preoperative services, surgical operation and uncomplicated postoperative-care visits
- **Global period:** a global period is the period of time in which necessary services furnished by a provider are included in the global allowance for a procedure
- **Incidental procedure**: an incidental procedure is performed at the same time as a more complex primary procedure; the incidental procedure requires minimum additional resources and/or is clinically integral to the performance of the primary procedure; procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied
- **Level of care**: the intensity of professional medical care required to achieve the treatment objectives for a specific episode of care
- **Medical necessity criteria**: medically necessary services are all services that a medical practitioner exercising prudent clinical judgment would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:
    - In accordance with generally accepted standards of medical practice
    - Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease
    - Not primarily for the convenience of the covered individual, physician or other health care provider
    - Not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease
- **Medical records:** reports, notes, photographs, X-rays or other recorded data or information (whether maintained in written, electronic or another form) that is received or produced by a health care provider or any person employed by the provider to document an episode of care; these items contain information relating to the medical history, examination, diagnosis or treatment of the member for an identified episode of care for specific dates of service
- **Modifier**: modifiers are two-digit codes appended to a HCPCS code when appropriate; a modifier can consist of numeric or alphanumeric characters; modifiers provide payers

with the additional information needed to process a claim, and they allow providers to indicate that a service for which the basic code description has not changed was altered or affected by some special circumstance

- **Mutually exclusive procedures**: two or more procedures that differ in technique or approach but lead to the same outcome; an initial service and subsequent service are considered mutually exclusive
- **Recoupment of payments:** retraction of monies paid to providers from future payments
- **Recovery of payments:** request for provider to return payment
- **Routine medical and surgical supplies**: supplies that are customarily used in small quantities, usually included in the provider's supplies and not designated for a specific patient
- **Unbundled services:** individual procedure codes are billed when it is more appropriate to bill a single comprehensive code that indicates the specific group of procedures was performed