	Reimbursement Policy

Subject: Emergency Services: Nonparticipating Providers and Facilities

Effective Date: **10/01/17**	Committee Approval Obtained: **09/30/19**	Section: **Administration**

***** The most current version of our 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/DC. *****

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 an enrollee's Amerigroup District of Columbia, Inc. benefit plan. The determination that a service, procedure, item, etc. is covered under an enrollee'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 enrollee'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 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 These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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, district, federal or CMS contracts and/or requirements indicate otherwise. Unless otherwise required by federal and/or District regulation or contract, reimbursement is based on the following: • **For Medicaid product lines only:** The amount that would have been reimbursed to the provider according to Washington, D.C.'s District Fee-for-Service (FFS) Medicaid program

	Note: Maryland hospital facilities reimbursement is based on the amount that would have been reimbursed to the provider according to Maryland's state FFS Medicaid program. • **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 (EMTALA) 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 1 January 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 its payment methodology according to Washington, D.C.'s FFS Medicaid Program guidance. 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.
History	• Biennial review approved **09/30/19**: Policy template updated • Initial policy approved **07/19/17** and effective **10/01/17**
	• This policy has been developed through consideration of the following:

References and Research Materials	• CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance • Deficit Reduction Act of 2005 (Pub.L. No. 109-171) • Emergency Medical Treatment and Labor Act (EMTALA)
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• 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	• None