	Reimbursement Policy

Subject: Claims Submission — Required Information for Professional Providers

Effective Date: **10/01/17**	Committee Approval Obtained: **07/19/17**	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 by Amerigroup District of Columbia, Inc. 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 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 These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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	Professional providers of health care services are required unless otherwise stipulated in their contract to submit an original CMS-1500 Health Insurance Claim Form to us for payment of health care services. Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup will deny payment without being liable for interest or penalties. The

	CMS-1500 claim form must include the following information if applicable:
	• Patient information (name, address including ZIP code, date of birth, gender, relationship to insured and medical condition as related to employment or an accident)
	• Insured's information (member ID number; name; address including ZIP code; policy, group or FECA number; name of insurance plan or program; and name of other health benefit plan)
	• Coordination of benefits/other insured's information (name, policy or group number, and name of insurance plan or program)
	• Name of referring physician or source
	• Indication of outside laboratory or ICD-10 diagnosis code(s)
	• Clinical Laboratory Improvement Act certification number
	• Date(s) of service(s) rendered
	• Place of service
	• Procedures, services or supplies (description of services rendered using CPT-4 codes/HCPCS codes and appropriate modifiers)
	• Charge(s) for service(s) rendered
	• Day(s) or unit(s) related to service(s) rendered
	• Total charges and amount paid by patient
	• Federal tax identification number
	• Name and address of facility where services were rendered and the NPI of the service facility if applicable
	• NPI:
	  ○ Individual servicing provider's NPI must be reported as the rendering provider ID if applicable
	  ○ When billing is from a group, the group's NPI must be reported as the billing provider if applicable
	• NPI and other non-NPI identifier of the referring, ordering or supervising provider
	• Billing provider information (name, address including ZIP code, and telephone number)
	• Indication of signature on file — a handwritten or computer generated signature for the provider of service or his/her representative — and date the form was signed
	• National Drug Code(s) (NDC) to include the NDC number, unit price, quantity and composite measure per drug
	
	Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

	Although Amerigroup prefers the submission of claims electronically through the electronic data interchange (EDI), Amerigroup will accept paper claims. A paper claim must be submitted on an original claim form with drop-out red ink, be computer-printed or typed, and in a large, dark font in order to be read by optical character reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.
History	• Initial review approved **07/19/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance • National Uniform Claim Committee
Definitions	• **General Reimbursement Policy Definitions**
Related Policies/ Procedures	• Acceptance of Altered Claim Forms • Claims Requiring Additional Documentation • Claims Submission — Required Information for Facilities • Drugs and Injectable Limits • Modifier Usage • Other Provider Preventable Conditions (OPPC) • Unlisted or Miscellaneous Codes
Related Materials	• None