	Reimbursement Policy

Subject: Claims Submission — Required Information for Facilities

Effective Date: **04/30/19**	Committee Approval Obtained: **04/30/19**	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/IA.*****

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 Iowa, 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 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 its policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original CMS UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to Amerigroup for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim, and Amerigroup can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include the following information, if applicable: • Billing provider information (name, address and telephone number)

	• Patient Control Number
	• Type of Bill
	• Federal Tax Identification Number
	• Statement Covers Period (From-Through)
	• Patient information (name, member ID number, address, date of birth and gender)
	• Admission/start of care date
	• Type of admission or visit
	• Point of origin for admission or visit
	• Patient discharge status
	• Condition code(s)
	• Occurrence code(s) and date(s)
	• Occurrence span code(s) and date(s) for inpatient services only
	• Value codes and amounts
	• Revenue code(s) and applicable corresponding CPT/HCPCS codes, if necessary:
	  ○ Applicable claims billed only with the revenue code will be denied.
	  ○ Providers will be asked to resubmit with the correct CPT/HCPCS code in conjunction with the applicable revenue code.
	• Date(s), unit(s), total charge(s) and noncovered charge(s) of service(s) rendered
	• Clinical Laboratory Improvement Amendment (CLIA) certification number
	• Insurance payer's information (name, provider number, and Coordination of Benefits [COB] secondary and tertiary payer information)
	• Prior payments — payers, if applicable
	• Insured's information (name, relationship to patient, member ID number, and insurance group name and number)
	• Principal, admitting and other ICD-9 diagnosis codes, including 4th and 5th digit when required or all seven digits for ICD-10
	• Present on Admission (POA) indicator, as applicable
	• Diagnosis and procedure code qualifier (ICD-9 procedure or all seven digits for ICD-10) and date of principal procedure for inpatient services, if applicable
	NOTE: Do not report ICD-10-CM and ICD-10-PCS codes for claims with dates of service prior to implementation of ICD-10-CM/ICD-10-PCS, on either the old or revised version of the UB-04/CMS-1450 claim form.
	• National Provider Identifier Provider Number (in accordance with CMS requirements)

	• Encounter reporting data elements in accordance with applicable state compliance requirements, including the following:
	  ○ Admission source code
	  ○ Applicable value code for billed admission type code
	  ○ Birth weight with applicable value and admission type codes
	  ○ Facility type code
	  ○ 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. Claims that have been altered 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 dropout red ink, 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	• Biennial review approved and effective **04/30/19**: Policy language updated • Initial approval **08/04/15** and effective **04/01/16**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contract
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Claims Submission — Required Information for Professional Providers • Corrected Claims • Drugs and Injectable Limits • Other Provider Preventable Conditions (OPPC) • Present on Admission Indicator for Health Care-Acquired Conditions • Unlisted, Unspecified or Miscellaneous Codes
Related Materials	• Amerigroup Electronic Data Interchange Manual