	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/TX.*****

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 STAR+PLUS MMP (Medicare-Medicaid Plan) benefits. 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 STAR+PLUS MMP may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR+PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP 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 no more than the amount that would have been reimbursed to the provider if the beneficiary were enrolled in original Medicare.

	Amerigroup STAR+PLUS MMP adheres to the requirements of the Emergency Medical Treatment and Labor Act. Amerigroup STAR+PLUS MMP 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 reimbursement policies for Eligible Billed Charges, Code and Clinical Editing Guidelines, and Claims Requiring Additional Documentation.
Exemptions	Amerigroup — Texas 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 Deficit Reduction Act (DRA) of 2005, Sec. 6085. Amerigroup — Texas and Amerigroup — Insurance Company adhere to the requirements of the Federal Medicaid Managed Care Regulations and shall develop and maintain a record, pursuant to DRA stipulations, for Amerigroup — Texas and Amerigroup — Insurance Company payment methodology according to Texas's Fee-for-Service (FFS) Medicaid program. Unless otherwise required by federal and/or state regulation or contract, reimbursement is based on no more than the amount that would have been reimbursed to the provider according to the Texas state FFS Medicaid Program. • Amerigroup — Texas and Amerigroup — Insurance Company will act in accordance with the 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."
History	• Biennial review approved **09/30/19**: Policy template updated • Initial policy approved **04/03/17** and effective **10/01/17**

References and Research Materials	This policy has been developed through consideration of the following: • CMS policies • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC • Deficit Reduction Act of 2005 (Pub.L. No. 109-171) • Emergency Medical Treatment and Labor Act
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