Provider Bulletin

Reimbursement Policy

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Community Care benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx.

New policy

Inpatient Facility Transfers
(Policy 13-002, effective 02/01/2015)

Amerigroup allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for the same episode of care, in compliance with federal and/or state guidelines and/or regulations regarding facility transfers payment.

In the absence of such guidelines, Amerigroup will use the following criteria:

- The transferring facility will receive a calculated per diem rate based on the length of stay, not to exceed the amount that would have been paid if the patient had been discharged to another setting
- The receiving facility will receive full diagnosis related group (DRG) payment

This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.

To view specific criteria for Inpatient Facility Transfers, please refer to the policy at providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx.

Policy update

Requirements for Documentation of Proof of Timely Filing
(Policy 06-133, originally effective 11/15/2006)

Amerigroup will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements when a provider can provide proof of a date of claim receipt compliant with applicable timely filing requirements or demonstrate good cause exists.

Good cause may be established by the following:

- If the claim includes an explanation for the delay (or other evidence that establishes the reason), Amerigroup will determine good cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, Amerigroup will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claims filing delay was due to:

- Administrative error – incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary or CMS) to the physician or supplier
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence

- Unusual, unavoidable, or other circumstances beyond the service provider's control which demonstrate that the physician or supplier could not reasonably be expected to have been aware of the need to file timely
- Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's negligence or intentional misconduct

To view more information about Requirements for Documentation of Proof of Timely Filing, please refer to the policy at providers.amerigroup.com/QuickTools/ Pages/ReimbursementPolicies.aspx.

Clarification of a policy

We previously distributed the **Inpatient Readmissions** policy bulletin without exclusion criteria listed. The Amerigroup Inpatient Readmissions policy excludes admissions for medical treatment of cancer, primary psychiatric disease, rehabilitation care, planned readmissions, patient transfers from one acute care hospital to another and patients discharged from hospitals against medical advice. The revised policy information is below.

Inpatient Readmissions
(Policy 13-001, effective 10/01/2013)

Amerigroup does not allow separate reimbursements for claims identified as readmissions to the same hospital for the same, similar or related conditions. The following standards will be used to determine whether a claim fits the above definition:

- The readmission occurred up to 30 days from the discharge.
- The readmission is for the same diagnosis or diagnoses that fall into the same grouping as the previous admission.

Exclusions:

- Admissions for the medical treatment of cancer, primary psychiatric disease and rehabilitation care
- Planned readmissions
- Patient transfers from one acute care hospital to another
- Patient discharged from the hospital against medical advice

This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.

Don't forget to use appropriate discharge status codes for all inpatient claims submissions. Use of the wrong discharge status code could result in an inappropriate reimbursement or denial.

For a complete list of reimbursement policies and clinical policy bulletins, visit providers.amerigroup.com and select Quick Tools. Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative or call 1-800-454-3730.

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New Policy

Maternity Services
(Policy 14-001, originally effective 2/1/2015)

Amerigroup policy allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same Federal Tax Identification Number (TIN). Reimbursement is based on all aspects of the global obstetric care package (i.e. antepartum, delivery and postpartum). In the event a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the same pregnancy. In the event that Global, Delivery Only, Delivery/Postpartum, Antepartum only or Postpartum Only services have been paid for the same pregnancy, a claim for Global services may be denied or may cause a previously paid claim for overlapping services to be recouped.

What is included in the Global Package?
The following elements of the global package are not separately reimbursable when any CPT code for global services is billed:

- Initial and subsequent history and physical exams when diagnosis of pregnancy has already been established
- All routine prenatal visits until delivery (typically monthly through 28 weeks, then biweekly until 36 weeks, and weekly until delivery) – usually 13 visits
- Additional visits for a high-risk pregnancy, *potential* problems, or *history of* problems that do not actually develop or are not active in the current pregnancy
- Collection of weight, blood pressure and fetal heart tones
- Routine urinalysis
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E&M) services that occur within 24 hours of delivery
- Management of uncomplicated labor (including administration of labor-inducing agents)

- Insertion of cervical dilators when this occurs on the same date of the delivery
- Simple removal of cerclage
- Vaginal (including forceps or vacuum-assisted delivery) or cesarean delivery of single gestation
- Delivery of the placenta
- Repair of first- or second-degree lacerations
- Uncomplicated inpatient visits following delivery
- Routine outpatient E&M services within six weeks of delivery
- Discussion of contraception
- Postpartum care only
- Education on breast feeding, lactation, exercise or nutrition

Policy update

Modifier 63: Procedure Performed on Infants less than 4 kg

(Policy 06-015, effective 2/1/2015)

Amerigroup reimburses **120 percent** of the applicable fee schedule (not to exceed the billed charges) or contracted/negotiated rate for the procedure code when the modifier is valid for services performed. Medical records may be requested for review to support the additional payment. The neonate weight should be documented clearly in the report for the service.

When an assistant surgeon is used and/or multiple procedures are performed on neonates or infants less than 4 kg in the same operative session, assistant surgeon and/or multiple procedure rules and fee reductions apply.

Please note that state-specific exemptions apply to Maternity Services and Modifier 63.
For additional information, for Maternity Services and Modifier 63, please view the policies at https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx.

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